This is a digital copy of a book that was preserved for generations on library shelves before it was carefully scanned by Google as part of a project to make the world's books discoverable online.

It has survived long enough for the copyright to expire and the book to enter the public domain. A public domain book is one that was never subject to copyright or whose legal copyright term has expired. Whether a book is in the public domain may vary country to country. Public domain books are our gateways to the past, representing a wealth of history, culture and knowledge that's often difficult to discover.

Marks, notations and other marginalia present in the original volume will appear in this file - a reminder of this book's long journey from the publisher to a library and finally to you.

Usage guidelines

Google is proud to partner with libraries to digitize public domain materials and make them widely accessible. Public domain books belong to the public and we are merely their custodians. Nevertheless, this work is expensive, so in order to keep providing this resource, we have taken steps to prevent abuse by commercial parties, including placing technical restrictions on automated querying.

We also ask that you:

+ *Make non-commercial use of the files* We designed Google Book Search for use by individuals, and we request that you use these files for personal, non-commercial purposes.

+ *Refrain from automated querying* Do not send automated queries of any sort to Google's system: If you are conducting research on machine translation, optical character recognition or other areas where access to a large amount of text is helpful, please contact us. We encourage the use of public domain materials for these purposes and may be able to help.

+ *Maintain attribution* The Google "watermark" you see on each file is essential for informing people about this project and helping them find additional materials through Google Book Search. Please do not remove it.

+ *Keep it legal* Whatever your use, remember that you are responsible for ensuring that what you are doing is legal. Do not assume that just because we believe a book is in the public domain for users in the United States, that the work is also in the public domain for users in other countries. Whether a book is still in copyright varies from country to country, and we can't offer guidance on whether any specific use of any specific book is allowed. Please do not assume that a book's appearance in Google Book Search means it can be used in any manner anywhere in the world. Copyright infringement liability can be quite severe.

About Google Book Search

Google's mission is to organize the world's information and to make it universally accessible and useful. Google Book Search helps readers discover the world's books while helping authors and publishers reach new audiences. You can search through the full text of this book on the web at `http://books.google.com/`

B.P.63

TRANSACTIONS

OF THE

Homœopathic Medical Society

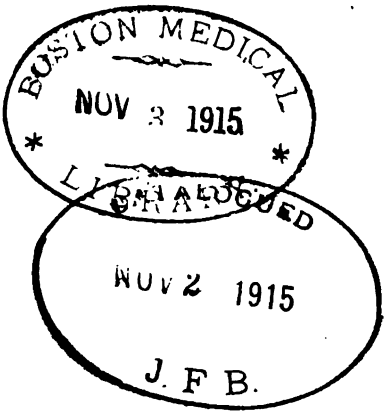
OF THE

STATE OF NEW YORK

FOR THE YEAR 1892.

VOLUME XXVII.

EDITED BY THE SECRETARY:
JOHN L. MOFFAT, M. D.



Rochester Democrat and Chronicle Print.
1892.

CONTENTS.

OFFICERS, - - - - - - - - - - 4, 5, 33, 430
FORTY-FIRST ANNUAL MEETING, - - - - - - - 7
FORTY-FIRST SEMI-ANNUAL MEETING, - - - - - - 150
PRESIDENTIAL ADDRESSES, - - - - - - - 7, 151
REPORTS OF:
Treasurer, - - - - - - - - - 13
Necrologist, - - - - - - - - - 17
Board of Censors, - - - - - - 12, 32, 159
Committees on:
Attendance, - - - - - - 13, 160
Investigation of Drug Effects, - - - 15
Reinstating Members, - - - - 27
Revising Constitution and By-Laws, - - 28
President's Address, - - - - 31, 164
Legislation, - - - - - - 167, 376
BUREAUS:
Clinical Medicine, - - - - - 141, 177
Gynæcology, - - - - - - - 207
Laryngology and Rhinology, - - - - 50, 272
Materia Medica, - - - - - - 145, 162
Mental and Nervous Diseases, - - - - 79, 256
Obstetrics, - - - - - - - 93, 234
Ophthalmology and Otology, - - - - 60, 296
Pædology, - - - - - - - 199
Public Health, - - - - - - - 169
Surgery, - - - - - - - 114, 339
APPENDIX, - - - - - - - - - 35, 367
BIOGRAPHICAL NOTE OF PRESIDENT FISKE, - - - 417
STATE BOARD OF MEDICAL EXAMINERS, - - - 6, 35, 411, 429
COMMITTEE ON LEGISLATION'S DOCUMENTS, - - - 378
CONSTITUTION AND BY-LAWS, - - - - - - 419
LIST OF NOMINEES FOR THE REGENT'S DEGREE, - - - 427
LIST OF HONORARY MEMBERS, - - - - - - 428
DEATHS DURING THE YEAR, - - - - - - 429
LIST OF OFFICERS, - - - - - - - - 430
LIST OF MEMBERS DROPPED, - - - - - - 432
ROLL OF PERMANENT AND DELEGATE MEMBERS, - - 433
STATE DIRECTORY, - - - - - - - - 447
INDEX, - - - - - - - - - - 488
ERRATA, - - - - - - - - - - 489

OFFICERS 1891-92.

President,

F. PARK LEWIS, - - - - - - - - Buffalo.

Vice-Presidents,

A. B. NORTON, - New York. | L. L. BRAINARD, - Little Falls.
J. W. SHELDON, Syracuse.

Secretary,

JOHN L. MOFFAT, - - - - - - - - Brooklyn.

Treasurer,

CHARLES DEADY, - - - - - - - - New York.

Necrologist,

H. D. SCHENCK, - - - - - - - - Brooklyn.

CENSORS.*

Southern District,		*Middle District,*	
E. CHAPIN,	Brooklyn,	F. F. LAIRD,	Utica,
E. J. PRATT,	New York,	GEO. F. HAND,	Binghamton.
N. ROBINSON,	Brooklyn.	J. W. CANDEE.	Syracuse.

Eastern District.		*Western District.*	
H. M. PAINE,	Albany,	A. R. WRIGHT,	Buffalo,
W. E. MILBANK,	Albany,	W. B. GIFFORD,	Attica,
GEO. E. GORHAM,	Albany.	E. J. BISSELL,	Rochester.

CHAIRMEN OF BUREAUS.

T. F. ALLEN, - - - - - - - - Materia Medica.
A. R. WRIGHT, - - - - - Clinical Medicine and Pathology.
J. M. LEE, - - - - - - - - - Surgery.
CHAS. E. WALKER, - - - - - - - - Obstetrics.
H. M. DAYFOOT, - - - - - - - - Gynæcology.
MARTIN DESCHERE, - - - - - - - - Pædology.
W. M. BUTLER, - - - - - - Mental and Nervous Diseases.
CHARLES DEADY, - - - - - Ophthalmology and Otology.
CHARLES E. TEETS, - - - - - - - - Laryngology.
WM. H. WATSON, - - - - - - - - Public Health.

*The Censorial Districts embrace the following counties:

SOUTHERN DISTRICT—Dutchess, Kings, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Ulster, Westchester.

EASTERN DISTRICT—Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton and Hamilton, Greene, Herkimer, Montgomery, Otsego, Rensselaer, St. Lawrence, Saratoga, Schenectady, Schoharie, Warren, Washington.

MIDDLE DISTRICT—Allegany, Broome, Cattaraugus, Chemung, Chenango, Jefferson, Lewis, Livingston, Madison, Oneida, Schuyler, Steuben, Tioga, Tompkins.

WESTERN DISTRICT—Cayuga, Chautauqua, Cortland, Erie, Genesee, Monroe, Niagara, Onondaga, Ontario, Orleans, Seneca, Wayne, Wyoming, Yates.

STANDING COMMITTEES.

Medical Legislation.

J. M. SCHLEY, Chairman.

S. H. TALCOTT, M. O. TERRY, E. HASBROUCK,
H. M. PAINE, GEO. E. GORHAM, A. R. WRIGHT,
ASA S. COUCH, GEO. M. DILLOW, H. M. DAYFOOT.

To Nominate for State Medical Examiners.

N. B. COVERT, Chairman,

F. E. DOUGHTY, W. T. LAIRD,
J. T. GREENLEAF, M. E. GRAHAM.

Investigation of Drug Effects.

M. W. VAN DENBURG, Chairman,

J. T. COOK, GEO. G. SHELTON, A. B. CARR,
JOHN L. MOFFAT, ST. CLAIR SMITH.

OFFICERS 1892-93.

President,

William M. L. Fiske, - - - 484 Bedford Av., Brooklyn.

Vice Presidents,

L. A. BULL, - Buffalo, | ELMER J. BISSELL, - Rochester,
J. W. CANDEE, Syracuse.

Secretary,

JOHN L. MOFFAT, - - - 17 Schermerhorn St., Brooklyn.

Treasurer,

CHARLES DEADY, - - - - 110 W. 48th St., New York.

Necrologist,

H. D. Schenck, - - - - 241 McDonough St., Brooklyn.

CENSORS.

E. HASBROUCK, Brooklyn, - - - - (*Southern District.*)
M. O. TERRY, Utica, - - - - - (*Middle* "
CHAS. E. JONES, Albany, - - - - (*Eastern* "
W. E. MILBANK, Albany, - - - - (*Eastern* "
GEO. E. GORHAM, Albany, - - - - (*Eastern* "
F. F. LAIRD, Utica, - - - - - (*Middle* "
J. W. CANDEE, Syracuse, - - - - (*Middle* "
NEWTON M. COLLINS, Rochester, - - - (*Western* "
EUGENE H. PORTER, New York, - - - (*Southern* "
JOHN S. HALBERT, Buffalo, - - - - (*Western* "
GEO. M. HAYWOOD, Rochester, - - - (*Western* "
IRVING TOWNSEND, New York, - - - (*Southern* "

STANDING COMMITTEES.

To Nominate for State Medical Examiners.

F. E. DOUGHTY, Chairman,

GEO. M. DILLOW,
M. E. GRAHAM,
EDWARD CHAPIN,
HARRISON WILLIS.

Medical Legislation.

G. E. GORHAM, Chairman.
A. S. COUCH,
J. M. SCHLEY,
M. O. TERRY,
H. M. PAINE, Secretary.
J. M. LEE,
JAY W. SHELDON,
N. ROBINSON,
F. PARK LEWIS.

STATE BOARD OF MEDICAL EXAMINERS REPRESENTING THIS SOCIETY.

To Serve till 1893.

JAY W. SHELDON, - - - - - - - - Syracuse.
JOHN McE. WETMORE, - - - - - - - New York.

To Serve till 1894.

ASA S. COUCH, - - - - - - - - - Fredonia.
HORACE M. PAINE, - - - - - - - - Albany.
WILLIAM S. SEARLE, - - - - - - - - Brooklyn.

To Serve till 1895.

EDWIN H. WOLCOTT, - - - - - - - - Rochester.
ANDREW R. WRIGHT, - - - - - - - Buffalo.

BOSTON MEDICAL
NOV 8 19

PROCEEDINGS

OF THE

Forty-first Annual Meeting, held at Albany, February 9th and 10th, 1892.*

FIRST DAY.—Morning Session.

President F. Park Lewis called the meeting to order at 10:30 A. M. Tuesday, February 9th, in the Common Council Chamber, City Hall and prayer was offered by Rev. James McLeod of the First Congregational Church.

PRESIDENT'S ADDRESS.

Gentlemen: —

At our Semi-Annual Meeting in September, I had the pleasure of considering with you our position as members of a school of medicine, and of emphasizing more particularly our rights and our duties as homœopathists. I wish in a very few words, at this time, to supplement what I then said by suggesting to you another aspect of the same subject, and in opening our 41st Annual Session I should like to sketch in outline, with your permission, the position which we occupy in the broad field of medical practice.

The aim of the truest scientist, the truest humanitarian, the truest physician, is not the strengthening of any doctrine or organization at the expense of truth, but rather the widening of horizons, the broadening of views, the deepening of experiences until the greatest truths come within reach; until, to minds made ready by their untrammeled, earnest, reverent attitude toward them can come some glimpse of the Eternal Verities. The spirit of large, reasonable, tolerant investigation has marked for its own every department of thought to-day. It is strongly apparent in the evolution of theology. The more conservative religious belief has not escaped the influence of this wave of progress. It would seem as though men are no longer struggling for the supremacy of certain dogmas, but that the great mass of mankind is earnestly, and with humility, asking "What is truth?" In no line of thought can preconceived ideas any longer be maintained, unless

*Stenographer, Frank Kraft, M. D.

substantiated by demonstrable facts. The shackles of custom and of habit that hamper, that hinder independent investigation are not easily thrown off, and the thought of yesterday, or rather the influence of the thought of yesterday, embarrasses and impedes the free working of the mind to-day. And yet, in spite of this, we find that the sympathy and encouragement of the great thinking, *working* body of men is with those who are "in thought free, in spirit reverent, in method scientific." And this should be the attitude of every thoughtful man toward the *medicine* of to-day. A physician can by no possibility be in the vanguard of progress unless he be receptive of all that is good, *let its source be what it may.* The medicine of to-day is vastly different from the medicine of one or two decades ago. It recognizes no less the value of drugs properly applied, but it recognizes more the value of the physician's knowledge, *which may prevent the necessity of drug giving.*

And, if by our own council-fire we may be permitted to speak freely to each other, I am inclined to the belief that we would all be better physicians if we would supplement our remedies, or even, possibly, replace them more frequently by a broader, profounder and more wide-searching knowledge of the laws that govern human life. If we would more thoughtfully and carefully study the laws of physiology and psychology. If we would consider more seriously what a man should "eat, what he should drink, and wherewithal he should be clothed"—not in defiance of the scriptural injunction, but in reverent consideration of those great questions of hygiene and sanitation, of food properties and of the relation through them of Nature's laws to health and disease. If more of our daily meditation ran upon these lines, upon the effects of rest and labor, of altitude and of temperature, if, in a word, our aim were rather to prevent than to cure that which might have been prevented, we would undoubtedly lessen the necessity of drug-giving, while we would enormously contribute to life-saving. To a very large extent I know this is done and just to the degree that it is done is the standard of medical education unconsciously raised by common consent to the level which the physicians themselves set.

Within the last decade, too, chemical, manual and mechanical methods have greatly advanced, vast strides have been made both in surgery and gynæcology, obstetrics has been wonderfully developed and ophthalmology has become almost a science. In all these broad fields of practice we educated physicians—of whatever denomination—stand together. The medical profession is divided to-day only

within the comparatively narrow limits of therapeutics, while even in the giving of drugs we may and do hold much in common. But the fact remains that the fundamental method of determining drug-action and of the administration of medicine is essentially different in the different schools, and consequently the whole future course of therapeutic study must lie in different lines. To the unprejudiced observer it would not seem as if this need be so serious a matter. And it would not, if men could honestly differ in medical opinion and discuss these opinions freely and frankly with each other in open session. We would then have far greater likelihood of reaching ultimate truth than we now have. But this cannot be accomplished in existing old school medical organizations.

The homœopathic physician *per se* is "*persona non grata*" in the allopathic camp, and this fact is a serious indictment against the scientific character and liberal tendency of the medical thought of the time.

In saying this, and in emphasizing it, I give the only reason for the existence of schools of medicine to-day.

If a physician may believe in the law of drug-action to which more than ten thousand of his confreres and many millions of people have given adherence after nearly a century's experience, if he may not believe this practice in accordance with his belief and still be admitted to good and regular standing in a society of brother physicians whose belief differs in therapeutics from his own, it makes imperative the continuance, as it did the establishment, not only of separate schools of medicine, but of separate medical organizations, separate hospitals, asylums and dispensaries. And so long as we are through this illiberality forced to maintain separate institutions, it becomes our duty to increase, to strengthen, to develop these institutions in their independence until they shall be second to none in the world. It was this illiberality toward freedom of thought which made necessary the three board system of medical examiners. It was a great strike in general medical progress when medical licensure was put under state control. At that time it may have seemed a narrow and partisan spirit that necessitated its division upon a therapeutic basis. But that which makes necessary the perpetuation of schools, makes equally essential, also, the divided medical board. And just as long as schools continue to exist the tripartite medical board must be their corollary.

Three separate boards of medical examiners were insisted upon and secured because there were essential differences of principle in the recognized systems of practice, and it is these differences which consti-

tute the tenets of the schools. Since some controversy has arisen concerning the question of tenets, it may be wise for us to clearly define the meaning of this word, and the position occupied by our school.

The word tenet comes from the Latin *tenere* to hold. Now that which we "hold" as physicians includes much that we cannot be said to "hold" as homœopathists. Homœopathy may have a very important bearing on a surgical case, or its use may modify a sanitary condition, but it can have absolutely no direct relation to surgery or sanitation. Homœopathy is a vastly important therapeutic field bounded within clearly defined and restricted limits. Its tenets consequently are also restricted and can be clearly and definitely expressed. The "tenets" of every educated physician may include homœopathy; they must include vastly more. Every member of this society is first a physician. He supplements his general medical culture by a knowledge of homœopathic therapeutics.

The law of the state demands that in materia medica and therapeutics the applicant shall be examined according to the tenets of the *school* to which he belongs, not of the *school men*. This necessarily restricts our examinations within homœopathic limits wholly. It would seem to be a valid argument that a man should be examined in all that he is to practice, and it would seem desirable also to place ourselves in a true and just light before the public by demonstrating through our examinations that our practice is comprehensive and inclusive.

But, to recapitulate, so long as absolute liberty of practice is only possible through the existence of separate schools, separate boards must follow, to insure the integrity of the schools. As this division of the board was based upon therapeutic differences, the law has specified, as the only expedient method of examination, that students should be examined in therapeutics in accordance with the "tenets" of their chosen school.

The "tenets" of the homœopathic system of practice, are those characteristic principles which belong to it exclusively While many of the methods of a homœopathic physician are subject to the universal law of progress, the special "tenets" of his *school* are fundamental principles and therefore invariable.

Strictly speaking, those principles which distinguish homœopathy from all other systems of medicine—that is to say, which constitute the "tenets" of the homœopathic school—may be summarized as follows: *The proving of drugs upon the healthy;* the *application of*

drugs according to the law of similars, and the *smallest curative dose.* When, therefore, a student comes before the State Board for his examination in materia medica and therapeutics, and, having chosen the homœopathic practice, is handed a sealed envelope with the name of our school upon it, I believe it to be legally impossible that that envelope should contain, and require answers to, questions outside of the strict lines of *homœopathic materia medica and therapeutics.* This limitation may prevent our demonstrating as fully as we might wish the broad qualifications of our students when they appear before the State Board. But when it is borne in mind that each of these applicants has not only been thoroughly examined by the Board in every other department of medicine, but has been favorably passed upon in *all* departments by his college faculty,—which latter test has up to this time been deemed alone sufficient—so much higher is the present standard that we need have little fear of medical incompetency.

I feel assured, gentlemen, that not in this matter only, but in all subjects that shall come up for our consideration the discussions will be temperate in tone, judicious in character and far-reaching in their influence, and that they will result, not in added medical knowledge only, but in an increase and a growth of the spirit of medical progress.

I take pleasure in announcing that the 41st Annual Meeting of our State Society is now open for business.

The President then announced the following committees:

On *Attendance.*—E. Hasbrouck, G. E. Gorham and M. W. Van Denburgh.

On *President's Address.*—W. M. L. Fiske, A. R. Wright, J. M. Lee.

Auditing.—Irving Townsend, L. A. Bull, A. B. Norton.

Tellers for Election of Officers.—W. M. Butler and J. T. Greenleaf.

Tellers for Election for State Medical Examiners.—M. E. Graham and N. Osborne.

The Secretary submitted the minutes as printed in Vol. XXVI, which, he announced, had appeared Jan. 13th—earlier than ever before.

The Secretary then presented communications from the Kings and New York County societies, forwarding the following resolutions, which had been adopted respectively on the 12th and 14th of January:

WHEREAS, The law establishing State Boards of Medical Examiners provides (N. Y. 1890, c. 507, § 5.) that "In the department of therapeutics, practice and materia medica, the questions shall be in harmony with the tenets of the school selected by the candidate"; and

WHEREAS, The Attorney General, in response to an inquiry for an interpretation of this law, has stated that some representative homœopathic body or person should say what the tenets of homœopathy are; be it

Resolved, The Homœopathic Medical Society of the County of Kings (also, of New York) respectfully petitions the Homœopathic Medical Society of the State of New York to instruct the homœopathic State Board of Medical Examiners that every practitioner of medicine should have a knowledge of the maximum doses of the more active remedies that may be administered safely, and also of the effects of overdoses.

Resolved, In the opinion of this Society the tenets of homœopathy embrace the following principles:

1st. *Similia Similibus Curantur* is a therapeutic law referring to the choice of the remedy;

2d. Provings on the healthy human being are essential to a proper knowledge of our remedies; and as a consequence of the above—verified by the experience of nearly a century—

3d. The administration of the single remedy

4th. In the smallest doses consistent with efficiency.

REPORT OF THE BOARD OF CENSORS.

Upon recommendation of the Censors the following 19 applicants were elected to permanent membership:

ALLEN, PAUL, M. D., New York, I*, 1889.
BABBITT, OTIS H., M. D., Cooperstown, I, 1882.
COVERT, RYNEAR B., M. D., Seneca Falls, I, 1868.
FRALICK, WILFRED G., M. D., New York, II, 1885.
FRAZIER, L. A., M. D., Amsterdam, III, 1881.
GIFFORD, ALDEN, M. D., Rome, IV, 1879.
HAMLIN, F. W., M. D., New York, I, 1888.
HATHAWAY, HENRY S., M. D., New York, I, 1891.
KNAPP, JAMES C., M. D., Geneva, I, 1884.
MARTIN, L. A., M. D., Binghamton, I, 1886.
PAIGE, H. WORTHINGTON, M. D., New York, I, 1884.
RABE, F. E., M. D., New York, I, 1883.
RUSSELL, H. EVERETT, M. D., New York, I, 1886.
SCHUMANN, CARL, M. D., Delhi, I, 1887.
SHEPARD, GEO. A., M. D., New York, I, 1889.
STEWART, J. A., M. D., Brooklyn, I, 1885.
STRONG, C. H., M. D., New York, V, 1874.
TUTTLE, EDWARD G., M. D., New York, I, 1889.
WHITE, A. LENORA, M. D., New York, VI, 1888.

* I—N. Y. Hom. Med. Col. and Hosp. II—Royal Col. P. & S., Canada. III—Albany Med. Col. IV—Hahnemann Col. of Chicago. V—Cleveland Hom. Hosp. Col. VI—Women's Med. Col. and Hosp. of N. Y.

THE REPORT OF THE COMMITTEE ON ATTENDANCE

showed 70 members registered and 8 visitors.

Albany County—S. H. Carroll, G. E. Gorham, C. E. Jones, W. E. Milbank, W. M. Nead, H. M. Paine, D. W. Pitts, L. M. Pratt, W. F. Robinson.

Broome County—E. E. Snyder.

Delaware County—Carl Schumann.

Erie County—L. A. Bull, F. Park Lewis, N. Osborne, A. R. Wright.

Fulton County—W. S. Garnsey.

Kings County—W. M. Butler, E. Chapin, F. E. Caldwell, W. Diehl, Jr., W. M. L. Fiske, E. Hasbrouck, Ida B. Hunt, G. C. Jeffery, John L. Moffat, N. Robinson, H. D. Schenck, W. S. Searle, H. Willis, W. B. Winchell.

Monroe County—E. J. Bissell, N. M. Collins, M. E. Graham, Geo. M. Haywood, J. M. Lee, Sarah I. Lee, C. R. Sumner, E. H. Wolcott.

New York County—T. F. Allen, A. Berghaus, F. H. Boynton, B. G. Clark, L. L. Danforth, Chas. Deady, H. M. Dearborn, J. H. Demarest, Geo. M. Dillow, F. E. Doughty, W. S. Miner, A. B. Norton, J. M. Schley, Geo. G. Shelton, T. Franklin Smith, C. E. Teets, Irving Townsend, E. G. Tuttle, S. F. Wilcox, G. W. Winterburn.

Onondaga County—J. W. Sheldon.

Orange County—S. H. Talcott.

Otsego County—O. H. Babbitt.

Rensselaer County—E. S. Coburn.

Saratoga County—T. C. Royal, J. A. Pearsall.

Schenectady County—D. E. Spoor.

Tioga County—J. T. Greenleaf.

Washington County—L. A. Clark, F. E. Lewis, M. W. Van Denburgh.

Connecticut—A. J. Givens.

TREASURER'S REPORT.

Dr. Deady submitted his annual report, as follows:

Chas. Deady, Treas., in account with Fund for Dr. Paine's Report, February 9th, 1892.

1891.			
Feb. 13,	To cash from A. B. Norton, late Treas.,	$589.70	
Mch. 10,	By cash paid Rochester P't'g Co.,		406.79
" 18,	By balance paid H. M. Paine,		182.91
		589.70	589.70

Charles Deady, Treasurer, in account with Hom. Med. Society State of New York, Feb. 9th, 1892.

Feb. 10, 1891, and 1892 to date.	To cash from A. B. Norton, late Treas.,	$ 585.71	
	" " " Permanent Members,	1068.00	
	" " " Co. Societies,	219.00	
	CONTRA.		
By cash paid out as per vouchers,			$1269.11
Balance on hand,			603.60
		$1872.71	$1872.71
	ASSETS.		
35 members 1 year in arrears,		$ 105 00	
15 " 2 " " "		90.00	
9 " 3 " " "		81.00	
6 Co. Societies in arrears to amount of		39.00	
Total assets,		$ 315.00	

Against the $585.71 balance received by the present Treasurer, there were bills standing to the amount of $627.94, leaving a deficit at the beginning of the current year of $42.23. To-day the society does not owe one dollar, except for the last Transactions, for which no bill has as yet been been received,* and against which there is a balance of $603.60.

In accordance with Art. II, §2 of our by-laws, Drs. Chas. A. Gwynn, Geo. W. Lewis, Jr., Wm. E. Long, J. D. V. Moore, R. S. True, and Chas. Zimmermann are reported as having failed to qualify for membership (have not paid the initiation fee), some of them dating back two or more years.

The following are dropped from membership for non-payment of dues (By-laws, Art. III, §3): Allen B. Carr, J. C. McPherson, Chas. M. Mosher, Clark Otis, Sarah Eddy Thorn and James A. West.

(Signed,) CHAS. DEADY, *Treasurer.*

The Treasurer read the following letter:

Kingston, N. Y., Jan. 18, 1892.

CHAS. DEADY, M. D.,

Dear Doctor:—Enclosed find P. O. money order for three dollars, to cancel accompanying bill which please receipt and return.

It will be impossible for me to attend annual meeting of State Society; am the victim of progressive locomotor ataxia, the result of traumatism. Am practically laid on the shelf so far as practicing is concerned. Please forward volume of Transactions.

Yours truly,

LEVI SHAFER.

In the discussion which ensued it was discovered that Dr. Shafer is not yet eligible to senior membership, so it was voted that he be excused from paying dues in future.

* Printing and distributing 450 Transactions, Vol. XXVI, pp. 444, was $598.66.

The Treasurer then presented two letters from Mark S. Purdy, protesting against being dropped for non-payment of dues and stating that he had moved to Detroit soon after joining and sent his resignation to Dr. Coburn with his initiation fee. Dr. Purdy also expressed a wish to be reinstated.

On motion it was voted, that Dr. Purdy's back dues having accumulated through a misunderstanding, they are hereby remitted and the Doctor re-instated in membership.

Dr. Deady presented the resignation of J. A. Biegler of Rochester, which, on motion, was accepted.

COMMITTEE ON MIDWIVES.

President Lewis reported (orally) that the State Board of Health has taken cognizance of the subject and is doing all that is possible. The committee was discharged, with thanks.

COMMITTEE ON INVESTIGATION OF DRUG EFFECTS.

M. W. Van Denburg, chairman, sent as his report a paper entitled "Has it been an oversight?" which will be found in the report of the bureau of Materia Medica.

DR. VAN DENBURG.—In view of the difficulty of enlisting others to take part in this work, and its manifest bearing upon Materia Medica topics, this committee should be merged with the latter named bureau. A great many of our homœopathic physicians speak of the value of allopathic therapeutics and my recent researches have predisposed me also in their favor, provided our study follow along the line indicated in my report. No drug in Stillé's two ponderous volumes fails to treat (1st) of its effects upon man, and (2d) its curative range. The law of similia is therefore, unconsciously perhaps, but unerringly foreshadowed and inculcated in its pages; I do not think a reasonable person could fail to be convinced to that effect. In homœopathic literature, of course, the curative effect is the major essential and is being constantly held up to the exclusion of the other effect. So if any weak-kneed homœopathic brother needs reference to and aid from allopathic sources direct him to Stillé. It would also be wise to remember this fact in our disputes with the avowed allopath who denies the value of our law, by referring him to his own standard text book and calling his attention to the examples quoted. There are many reasonable allopathic physicians who honestly believe that we are wrong in our theory. To such persons an appeal to reason as promulgated in their own literature would have a tendency to undo the bigotry with which early schooling and training may have invested them. That

kind of shot poured into the allopathic camp could not fail of ultimate effect. Or it could be done in a generous, gentlemanly fashion by writing up the remedy or remedies, either in our journals or in theirs, free of any personalities and presenting the facts to them in logical form. It is missionary work, but it is work that ought to be done.

M. E. GRAHAM.—In view of the vast importance of this subject, instead of merging it with any other bureau, I move that it be made a bureau by itself.

The SECRETARY reminded the speaker that the by-laws prescribe our bureaus. This work is important, but it belongs properly to the Bureau of Materia Medica—a bureau which has been not so well kept up as its importance demands. The bureau is comprehensive enough to admit this new subject matter, which, however, might be entrusted to a special committee within the bureau.

A. B. NORTON moved that the report be accepted and the committee discharged. So ordered.

The Auditing Committee reported the Treasurer's accounts correct, and was discharged.

On motion it was ordered that nominations for Senior or Honorary Membership and for the Regent's Degree shall be made in open session and referred to a committee.

W. M. Butler nominated for the Regent's Degree, HARRISON WILLIS, of Brooklyn, "the senior surgeon of our hospital, an ex-president of our county society, and the most sought consulting surgeon among us."

J. M. Lee presented the name of M. W. VAN DENBURG of Fort Edward: Well known as an earnest, hard worker in this society, an enthusiastic student and expounder of our therapeutic law, and a representative of the other aspect of our professional life, as contrasted with surgery.

After the names of Drs. Fiske (for President) and Lee, Osborne, Schley and Greenleaf, (for 1st Vice-President), had been presented, it was voted to refer the nomination of officers to a committee consisting of Drs. Lee, Greenleaf and Norton.

The NECROLOGIST'S REPORT was submitted by H. D. Schenck.

Report of the Necrologist.

H. D. SCHENCK, M. D.,

MR. PRESIDENT AND FELLOW MEMBERS:

The following nine deaths have come to my notice during the year: C. Judson Hill, Utica; Frederick I. Stacy, Binghamton; Edwin H. Hurd, Rochester; James H. Ward, Brooklyn; Austin W. Holden, Glens Falls; Ophelia S. Stull, Rochester; Samuel Lilienthal, San Francisco; C. A. Bacon, Sing Sing, and John W. Dowling, New York.

Of these I will present, at this time, sketches of the lives of C. Judson Hill, Frederick I. Stacy, Edwin H. Hurd, and A. W. Holden, and read by title, if there is no objection, those of Drs. J. H. Ward, Ophelia S. Stull, and R. B. Sullivan of Albany, who died in October 1890. I had been promised a biography of Dr. Lilienthal by Dr. Deschere, but it failed to arrive, as did that of Dr. Dowling. The material is not yet at hand for a sketch of Dr. Bacon.

C. JUDSON HILL, M. D.,

UTICA.

Dr. C. Judson Hill, whose death occurred on Feb. 14th, 1891, after a long illness, was born in Buford, Canada West, of American parents, Feb. 13th, 1830. Little is known of his life until he began the study of medicine with Dr. William H. Watson of Utica, in 1854. Here he continued while pursuing his studies at the Homœopathic Medical College of Philadelphia, from which he graduated in 1859. He immediately became a partner of Dr. Watson, a relation that continued until 1862, when he went to Albany, seeking a position on the medical staff of the army. After passing his examination the allopathic Surgeon-General, when he found Dr. Hill was a graduate from a homœopathic medical college, refused to issue his commission until ordered to do so by Gov. Edwin D. Morgan under pain of instant dismissal if he refused.

Dr. Hill served with the 91st regiment, N. Y. State Vols., for nearly three years. His precise and methodical habits admirably fitted him for duty as an army surgeon and were the cause of his being frequently detailed to organize hospitals, which he did very successfully in Florida and Louisiana. During this service the Doctor was detailed to the 15th Me. Regiment for service during the suspension of its surgeon for malpractice.

While serving in the marine hospital in New Orleans in the summer of 1863, Dr. Hill contracted typho-malarial fever, resulting in a severe inflammation of the liver with dropsy, which brought him home on sick leave in October of that year, and ever after gave him more or less trouble, finally causing his death. He returned to the front the next month, but the hard work of the Shenandoah campaign and his old trouble compelled him to resign in the winter of 1864-65. He was soon after breveted captain by Gov. Morgan. After a few months recuperation and complete rest he began practice in Utica, N. Y., where he continued until his death.

Dr. Hill was a member of the Homœopathic Medical Society of Oneida Co. from the time of his graduation in 1859, and was its President in 1866. He had been a member of this society since 1869. In the *Transactions* are found, scattered through fifteen vols., the following papers: "Toxicological Effects of Ergot," "Placenta Prævia," "Toxicological Effects of Ars." "Chorea," "Post-mortem Hæmorrhage," "Epistaxis," "Dropsy of Pregnancy," "Convulsions connected with the Puerperal State and Albuminuria," "Special Indications for the Selection of Various Remedies in Croup," "Indications for Phos. and Hyos. in Throat and Chest Symptoms," External Application of Remedial Agents, Prostatitis Treated by Chloride of Ammonia."

Oriental Lodge of Masons, the G. A. R., and the Royal Arcanum, besides several well-known social clubs of Utica, claimed the Doctor as an active member.

Dr. Hill was twice married. In 1864 he married the sister of Dr. W. H. Watson, who died in 1889. In 1890 he married Mrs. A. Marquisee, who, with W. R. Hill, his only son, survive him.

At a memorial meeting of the Homœopathic Medical Society of Oneida Co., held Feb. 16th, appropriate resolutions were passed and eulogistic speeches were made by many members, extolling his qualities as a courteous gentleman, a successful physician and an interesting writer. The County Society attended his funeral in a body on February 18th, 1891.

FREDERICK I. STACY, M. D.,

BINGHAMTON.

BY E. E. SNYDER, M. D.

Dr. Fred. I. Stacy was born in Harford, Cortland Co., N.Y., November 30th, 1860, where he lived until Feb., 1877. He was the son of William Stacy, a farmer by occupation and a gentleman of excellent reputation.

Dr. Stacy received his elementary education in the public schools of his native village until Feb., 1877, when he entered the Cortland Normal and Training School at the age of seventeen. He was always a good student and made excellent progress in his studies. He here pursued a classical course and was graduated with high honors June 28th 1881. The following September he entered the sophomore class in Liberal Art College, Syracuse University, where he remained one year, when he became principal of the High School at Union, N. Y., where he also remained one year. During this interval he decided to make medicine his profession, and so entered a medical college in Chicago where he took a course of lectures instead of returning to Syracuse University. In 1884 he matriculated in the Long Island Hospital Medical College, but completed his medical education in the N. Y. Homœopathic Medical College from which he graduated in April 1885. Soon after his graduation he located in Binghamton, N. Y., where he practiced medicine until he died, April 4th 1891, at the early age of thirty-one.

He was united in marriage to Miss Belle B. Badger, of Union, N. Y., March 17th, 1886. He was survived by his wife and infant son, the latter of which died Aug., 30th, 1891.

Following his death, a special meeting of the Broome Co. Homœopathic Medical Society was called and the following resolutions were adopted:

WHEREAS, In the providence of an all-wise Father, our dearly esteemed brother and co-laborer, Dr. F. I. Stacy, has been called to a world where sickness and death are unknown; therefore be it,

Resolved, That we, the members of the Broome County Homœopathic Medical Society, have parted with our beloved brother with sad hearts and deep sorrow, feeling that one of our brightest and most capable members has been taken just at the time when his life seemed most useful and helpful to his fellow men; and,

Resolved, That in him we recognized a conscientious, true and self-sacrificing physician, whose first and last thought was the speedy recovery of those under his care; and,

Resolved, That we do heartily and sincerely sympathize with his deeply afflicted family; and,

Resolved, That a copy of these resolutions be engrossed and presented to Mrs. Stacy, and also published in the daily papers.

Dr. Stacy possessed many sterling qualities for a successful physician. His prominent maxim in life was, "*I must succeed*," and he diligently applied all his energies to the accomplishment of this purpose. He was always faithful to every duty, self-sacrificing in the interest of his patients, strictly honest and cherished the warmest feelings of friendship for his many friends. He was entirely devoted to his profession and to the cause of homœopathy. These excellent qualities, with his liberal education, his noble christian character and sincere devotion to the best interests of his patients, won for him an excellent clientage, and made his death, at the very entrance of his useful life, deeply felt and mourned by his friends and colleagues.

His death was caused by cerebral meningitis due to overtaxation and La Grippe.

In the death of Dr. Stacy the New York Homœopathic Medical Society looses one of its most promising young members.

EDWIN H. HURD, M. D.,

ROCHESTER.

BY H. M. DAYFOOT, M. D.

Dr. Hurd was born in Dutchess County, N. Y., in 1825. His father, Curtiss J. Hurd, practiced medicine over fifty years in Sharon, Conn., and Dutchess County, and served as a surgeon in the war of 1812. Two brothers, George F. and Darwin E., also were physicians.

Dr. Edwin H. Hurd was educated in the schools of Dutchess and Onondaga counties, and commenced the study of medicine with his brother, and subsequently entered the office of Dr. M. L. Lea, of Fulton, Oswego County. In 1844 he attended the medical department of Geneva University, from which institution he graduated in 1847. He then practiced medicine as an old-school physician for two years in Caledonia, N. Y., when he removed to Rochester, embraced homœopathy and for several years was associated with the late Dr. M. M.

Mathews, the leading homœopathic physician in Western New York. In 1882 he formed a partnership with Dr. H. M. Dayfoot, which relation was continued until the time of his death.

He was a member of the County, State and National Societies. He was for one year Vice-President of the State Society and for three years President of the County Society. He joined the American Institute of Homœopathy in 1873. He was consulting physician to the Rochester Homœopathic Hospital, and always held a lively interest in the welfare of that institution.

At the time of his death Dr. Hurd was the oldest homœopathic physician in Rochester, and that he was one of the most popular and successful his large and devoted clientage fully attested. He was a natural physician, seeming to grasp intuitively the diagnosis and indications for treatment. He possessed in an eminent degree those essentials for the medical man—sound judgment and good common-sense. His pride was to keep abreast of the times in medical matters, and midnight often found him absorbed in the pages of his favorite journals. He was a man of sterling integrity, and his private life was unimpeachable. To sum it all up, he was a devoted husband, a loving father, a warm and trusty friend, a genial associate, a safe counselor and a skilled and faithful physician. His sympathetic and kindly nature endeared him to his patients, to whom his name will ever be a blessed memory.

For many years he had belonged to the Masonic fraternity, being a member of Cyrene Commandery, No. 39.

His death was caused from epithelioma of the tongue, the first symptoms of which were noticed in September, 1890, and notwithstanding medical and surgical treatment, and all the care that loving and devoted hearts could bestow, the disease advanced remorselessly to its fatal termination on May 15, 1891, at the age of sixty-four years.

Resolutions expressive of sympathy were adopted by the staff of the Rochester Homœopathic Hospital and the Monroe County Homœopathic Medical Society.

His wife and four daughters are amongst the many who mourn his loss.

AUSTIN WELLS HOLDEN, A. M., M. D.,

GLENS FALLS.

This former President and active member of our society was called to his rest July 19th 1891 at the age of 72. Dr. Holden was born in White Creek, Washington county, N. Y., May 16th 1819. His parents were natives of Barre, Mass., descendents from an English family by the name of Holden that early settled in Watertown, Mass.

At the age of four years he removed to Potsdam, St. Lawrence county, where he was educated by his kind step-mother and at the St. Lawrence Academy. In 1836 his father again moved, this time to Glens Falls, Warren county, which, with a brief intermission, was Dr. Holden's home to the time of his death. He now, at the age of 17, began the study of law with Hon. William Hay in Glens Falls, but lack of funds compelled him in a year to enter his father's cabinet-shop and learn cabinet making, a trade he followed until he was 22 years of age. His health beginning to fail he taught in a number of schools about Glens Falls. It was while thus engaged that he began the study of medicine with Dr. Tabor B. Reynolds. He also now found time to become well grounded in the sciences and to study the speculations of the Greek Philosophers.

In the winter of 1844 he attended his first course of lectures, at the Albany Medical College, but was unable to finish them as he was elected County Superintendent of Schools the following autumn, an office he held for two years. Then he resumed his medical studies, graduating from the Albany College in 1848.

Practice was begun in Warrensburgh, Warren county, where he remained four years. While here Dr. Holden was united in marriage to Elizabeth Buell of Glens Falls, whither he moved in May 1852 to take the practice of Dr. Donald B. McNiel. In 1857 the doctor was induced to investigate homœopathy and visited New York city to watch and study its practice, which he finally adopted and continued ever after to practice.

It was in 1856 that he had been commissioned a surgeon in the 31st regiment of the state militia, and when a call was made for volunteers at the beginning of the civil war, Dr. Holden was the first man in Warren county to tender his services. He enlisted a company of which he was made captain. This, with companies from the surrounding towns was made the 22d regiment N. Y. State Volunteers. After the first battle of Bull Run this regiment with three others from New

York were united into what was called the "Iron Brigade," for its gallantry at the second Bull Run, South Mountain, Antietam, and Fredericksburgh.

At the request of many officers and friends Dr. Holden was transferred in August 1862 to the medical staff as first assistant surgeon, acting most of the time as chief medical officer in the absence of the surgeon, until his regiment was mustered out of service in June 1863. Within six weeks he was commissioned an acting assistant surgeon in the U. S. A., and continued to perform active duty at Frederick City and Cumberland, Md., and at Troy, N. Y., until Lee's surrender. Gov. Fenton honored the doctor with a commission of Brevet Major of N. Y. Volunteers, for meritorious services at the close of the war.

Practice was again taken up on his return home and continued successfully until about two years before his death.

In 1869 he became a permanent member of this society, and has filled the offices of Censor, 3d Vice-President in 1871, and President in 1875. From 1883 to 1889 he was Necrologist. Among his contributions to the society's *Transactions* have been "Climatology of Warren Co.," "Gun Shot Wounds of the Liver," "Longevity," "A Sketch of the Rise and Progress of the Oriental Plague, traditionally known as the Black Death of the 14th Century," with many biographies and addresses. At the semi-annual meeting in Saratoga, in 1871, he gave an address upon the "Follies and Fallacies of the Medical Profession."

Since 1879, he has been a member and contributor to the American Institute of Homœopathy. He received also this same year the honorary degree of M. D. from the Regents, and in 1891 was made a senior member of this society. It was in 1871 that Union College conferred upon him the honorary degree of A. M.

At the request of some New York physicians Dr. Holden accepted an appointment as chief of staff of the Ward's Island Homœopathic Hospital in 1877, where he discharged his duties with great ability for two years when failing health compelled him to resign and resume practice in Glens Falls.

The formation of a medical board for the examination of pension claimants in Glens Falls in 1875 again called Dr. Holden into office, and he was its President from the formation until Jan. 1891.

In spite of being a Democrat in a strong Republican district and an extreme temperance advocate, he was held in so much esteem that he frequently held local offices and in 1873 was elected to the assembly on the Democratic ticket.

Leisure moments had been spent by him for many years in literary studies and researches into the local history, which he published in 1874, under the title of "A History of the Town of Queensbury, N. Y." For this he was made a corresponding member of the Oneida County Historical Society, the New York, Wisconsin and R. I. Historical Societies, and of the New York and the New England Geneological and Biographical Societies.

For fifty years Dr. Holden was an active worker and communicant in the Protestant Episcopal Church, and held the office of vestryman and warden for many years. He had also been made a lay reader by the Bishop.

Among his many other characteristics, this many-sided man was an enthusiastic worker in the field of secret societies and belonged to the Free Masons, I. O. O. F., B. P. O. of Elks, and the G. A. R. He was several times Master of each Masonic Lodge in Glens Falls, and was a Knights Templar. Most of the local temperance societies claimed his membership and active support, and in nearly all of them he had been an officer.

When the veteran organization of the 22d Regiment was formed, the doctor was its active supporter and first president. His duties in managing a regimental re-union in 1888 undermined his strength and he gradually began to fail. The sudden death of his loving companion and wife for forty years, in January 1891, just six months before his own, hastened his decline, and for two months before his death he was confined to his bed.

Of his three children one died in infancy, another, after graduating as a physician, died at the age of 27, and his remaining son, James A., survives him.

His appetite for books early led to their collection and at his death his general library was a very large and well read one, where he found great pleasure.

The offices which he most prized of the long list that had been conferred upon him was a member of the Board of Education and a trustee of the Glens Falls Academy. These he held for many years. With all these cares and his practice he found opportunity to contribute poems and various prose productions to the local papers of which he was at different times the local editor.

Ever public spirited and alert to advance every good project, he became one of the best known, respected and popular men in his neighborhood. With the calmness of a summer day and without pain, there closed, July 19th, 1891, this busy and useful life that had done much to

lighten the burdens of his fellow-men and to lift their lives to a higher plane. "A patriot when the nation needed patriots, a skilled and tender physician and surgeon, a good neighbor, a charitable churchman, a loving father—when such a man passes away words of commendation are superfluous. Dr. Holden's soul can stand before the Almighty Judge without fear and without reproach."

JAMES HENRY WARD, M. D.

BROOKLYN.

Dr. James H. Ward, one of the pioneers of homœopathy in the village of Williamsburg, now a part of Brooklyn, was born in Madison, N. J., in 1824. He graduated from the Medical Department of New York University at the age of twenty-four. After a practice of five years he went to Berlin where he pursued his studies under Virchow and Von Langenbeck, especially in the subjects of pathology and histology. Upon his return he was made Professor of the Theory and Practice of Medicine, in the N. Y. Hom. Med. Col.

The organization of the Hom. Med. Soc., of the County of Kings in 1857 gave him an opportunity of becoming one of its earliest members and remained so until he went to New York in 1860, when he married his faithful wife, Marie Louise Burton of Sandusky, Ohio, who with five sons and two daughters survive him.

Dr. Ward returned to Brooklyn in 1868 and practiced the remainder of his life in the Williamsburg section of that city, where he died in May, 1891.

He was a communicant and vestryman for many years in one of the oldest Episcopal churches in Brooklyn. He was also an active Free Mason at the time of his death. As a representative citizen Dr. Ward was for some years a member of the Brooklyn Board of Education, and for a number of years before his death was the medical director of the Brooklyn Maternity. He joined this society in 1890.

The doctor was not a writer, nor was he often heard or seen in our society meetings, but he filled a mind of keen observation with many practical and useful facts which were of great help to younger men with whom he was very glad to consult and advise. He was a man of commanding stature, which with his hearty, cheerful manner and apparent confidence, even in trying emergencies, inspired the respect and admiration of his patients.

OPHELIA S. STULL,

ROCHESTER.

Dr. Ophelia S. Stull, wife of Joseph A. Stull, of Rochester, was a daughter of Elisha and Charlotte Sibley and was born in Rush, N. Y., Dec. 19th, 1832. Her education was obtained in Cooperstown and in the Elmira Female College. At the age of twenty-four she was married and moved to Rochester. Thence, in five years, she removed to Rush Junction, where she lived thirteen years. In 1875 she returned to Rochester. She had studied medicine considerably at this time, and in 1881 graduated from the Hahnemann Medical College of Chicago. She took a post-graduate course here before beginning practice in Rochester. She was connected with a sanitarium opened in the building which is now the Rochester Homœopathic Hospital.

Dr. Stull was a member of the Homœopathic Medical Society of the County of Monroe, of the Western New York Homœopathic Society, of this society of which she became a member in 1890, and of the American Institute of Homœopathy. Her husband and four children, all of whom reside in Rochester, survive her. Her sudden death occurred Oct. 25, 1891, at the age of fifty-nine.

RICHARD BENNETT SULLIVAN.

This young man, cut down just as he was making a name in Albany, was born in Ithaca, N. Y., in 1850. After completing his education at the Ithaca Academy he began to study medicine with a distant relative, Dr. B. B. Schenck, of Plainville, N. Y., a former member of this society. He graduated from the New York Homœopathic Medical College in 1875. After services as resident physician in the Albany Homœopathic Hospital and at the Ward's Island Homœopathic Hospital, Dr. Sullivan began practice in Plainville, N. Y. In a few years he removed to Baldwinsville, N. Y., but in four years returned to Albany to devote himself exclusively to diseases of the eye and ear. During the next three years he devoted himself assiduously to his practice and gained the respect and confidence of colleagues and patients. His health failed under this work and he was attacked with a disease of the lungs. With a hope of mitigating it he removed to Colorado Springs where he at first improved. The trouble soon extended to the larynx, however, and he died of phthisis in Colorado, Oct. 25th 1890.

Dr. Sullivan was an active member of the various county and local societies of his various neighborhoods, and was twice secretary of the Homœopathic Medical Society of Onondaga Co. He was several times a delegate member to this society, and in 1884 became a permanent member.

He contributed to this society papers upon 'Traumatic Paraplegia and Epilepsy Cured by Arnica,' and one upon 'Crotalus Horridus.' To other societies he was a frequent contributor, among his papers being, The Causes and Treatment of Diphtheria, Chronic Suppurative Keratitis, The Special Indications for the Use of Naja Tripudians, and Chronic Catarrhal Inflammation of the Middle Ear.

At a special meeting of the Homœopathic Medical Society of Albany County, held Oct. 31st 1890, Dr. H. M. Paine presented a biographical sketch of Dr. Sullivan, and resolutions bearing testimony to his modesty, industry and devotion to medicine were passed after Drs. Pratt, Milbank and Gorham had spoken in praise of his singleness of purpose and devotion to medicine, and his success which had been attained by hard work and close application.

COMMITTEE ON WAYS AND MEANS FOR REINSTATING FORMER DELINQUENT MEMBERS.

A. B. Norton, chairman, moved to take this subject off the table;* voted.

He then presented the following resolutions:

WHEREAS, It has been proposed that members dropped for non-payment of dues, asking to be reinstated, should have their back dues remitted, and

WHEREAS, It would seem that such action would be prejudicial to the best interests of the society by encouraging delinquency; therefore

Resolved, That the power of reinstatement in such cases be vested in the Executive Committee, with the understanding that such leniency shall be exercised only in exceptional cases where unfortunate circumstances seem to render it necessary.

JOHN L. MOFFAT: I endorse Dr. Norton's resolutions most heartily. This is partly a question of bookkeeping, but also a matter of self-respect on the part of this society. To refer this whole question to the Executive Committee will meet all cases without putting particulars of any one of them on record. The Executive Committee can safely be trusted to have the best interests of the society at heart.

Being put to vote the resolutions were adopted.

*See p. 238, Transactions, 1891.

COMMITTEE ON REVISION OF CONSTITUTION AND BY-LAWS.

DR. MOFFAT: At our last meeting this committee made certain recommendations which had the force of notifications of motion to amend the by-laws:

1. To abolish the initiation fee, and to charge $2.00 for the certificate of membership.

2. To publish the names of those failing to qualify after election, as we do those dropped for non-payment of dues; and

3. To include Rhinology in the bureau of Laryngology.

Doubt having been expressed as to the possibility of libel suits arising from the publication of delinquent lists, the Committee sought legal advice and received the following opinion:

60 & 62 COTTON EXCHANGE, NEW YORK,
February 8th, 1892.

JOHN L. MOFFAT, M. D., Secretary.

Dear Sir:—I am asked whether the publication annually in the printed *Transactions* of the Homœopathic Medical Society of the State of New York, of a list of such former members of said society as may have been dropped from membership because of the non-payment of their dues, would render the society liable, either civilly or criminally, as for a libelous publication.

My answer is that if the facts will substantiate the publication, that is, if the individuals whose names are so published have in fact omitted to pay their dues so as to render themselves, under the provision of your constitution or by-laws, liable to be dropped from membership; and if by reason of such omission they have, as a matter of fact, been regularly dropped in the manner prescribed by your constitution or by-laws, proof of these facts would be a complete defense to any civil suit for damages which might be brought against your society, based upon such publication. The truth of the whole of any defamatory charge is always a complete defense to any civil action for libel or slander, even though the words complained of were spitefully and maliciously written or spoken.

It was in cases of criminal libel, that is where the State proceeds against the party charged with publishing the defamatory words, that the old maxim obtained: "The greater the truth the greater the libel." But as the Constitution of the State of New York expressly provides that: "In all criminal prosecutions or indictments for libel, the "truth may be given in evidence to the jury; and if it shall appear to "the jury that the matter charged as libelous is true and was published "with good motives and for justifiable ends, the party shall be

"acquitted," the jury having the right to determine both the law and the fact, proof of the circumstances I have stated above as affording a complete defense to any *civil* proceeding, together with proof of the circumstances under which the publication is made—that is, without malice or spite—would beyond peradventure of a doubt entitle your society to a verdict in its favor, even supposing that any District Attorney in the State of New York could be induced to bring such a charge before a Grand Jury for purposes of indictment.

I conclude that you would be reasonably justified in publishing the list you refer to. Very truly yours,

R. BURNHAM MOFFAT,
Counsellor at Law.

On motion of E. Hasbrouck it was voted to take up seriatim the proposed amendments.

On motion, it was voted to amend By-Law II, § 2, ¶ 3: by substituting "three" for "five" dollars; by striking out the words "a certificate of membership and to"; and by adding the words *except that a further fee of two dollars will be charged those desiring a certificate of membership.*

JOHN L. MOFFAT moved to amend ¶ 4, § 2, Art II, by adding the words *and his or her name shall be published each year in a special list in the back of the volume of Transactions.* Seconded.

L. A. BULL moved, as an amendment, that no application for membership be received unless the money accompanies it.

GEO. W. WINTERBURN: We want the young practitioners to join us, and this amendment of Dr. Bull's would tend to discourage them. As a business principle, however, it is a move in the right direction and I second it.

CHARLES DEADY: I know personally of nine or ten nominations which we would not have had if the money had been insisted upon at the time of solicitation.

A. B. NORTON: I am opposed to Dr. Bull's motion as it practically requires those who endorse an application to hold themselves financially responsible for the first year's dues.

On motion Dr. Bull's amendment was laid on the table.

T. FRANKLIN SMITH, speaking on the original question, opposed the publication of the names of those who failed to qualify because it makes a black list of persons who have never been members. In the American Institute of Homœopathy, when the time is reached for printing the *Transactions* the General Secretary submits to the Treasurer a list of those elected, and it is understood that only such

names will appear in the *Transactions* as have paid the Treasurer previous to going to press. They have never been members; then, why publish them.

JOHN L. MOFFAT: A man (or woman) who will not pay his first year's dues within the time prescribed cannot be relied upon to pay subsequently, and in all probability would not take an active part in the Society; however good a companion, physician, or surgeon he might be his name would be less an element of strength than of weakness, and its insertion in the proposed list might avoid the awkwardness arising should he be requested to again apply.

The amendment was adopted by a vote of 10 to 7.

On motion, Art. IV, § 2, was amended by adding the words *of each* after "Legislation and"; also by adding the words *and Rhinology* after "Laryngology."

The Committee was then discharged.

By consent, the society reverted to nominations, and A. R. WRIGHT presented the name of N. B. COVERT, of Geneva, for the Regent's Degree: "He has been a prominent physician and operator in his specialty (the eye and ear) and stands high all through Western New York. He has succeeded in stemming the tide of old school encroachment in his district; he has converted to homœopathy fully two-thirds of the people of Geneva and surrounding country."

JOHN L. MOFFAT nominated THEODORE Y. KINNE, of Paterson, N. J., as Honorary Member: As President of the American Institute of Homœopathy his reputation is world-wide, and

"None know him but to love him,
Nor name him but to praise."

AFTERNOON SESSION—3 P. M.

BUREAU OF PUBLIC HEALTH.

(No Report.)

BUREAU OF LARYNGOLOGY AND RHINOLOGY.

C. E. TEETS, Chairman, presented three papers:

"A Case of Intubation," by L. A. Bull;

"A Plea for Accurate Symptom Prescribing," by J. B. Garrison;

"Rhinitis Membranosa," by H. W. Paige.

BUREAU OF OPHTHALMOLOGY AND OTOLOGY.

CHAS. DEADY, Chairman, submitted five papers:

"A Comparison of Tests in Heterophoria," by E. J. Bissell;

"Hyoscyamine Hydrobromate," by John L. Moffat;
"Electricity in Diseases of the Eye," by A. B. Norton;
*"Three Cases of Retro-bulbar Neuritis," by C. C. Boyle;
*"A Case of Paralysis of the Eyelids, exhibiting some peculiar features, cured by Agaricus," by E. H. Linnell.

BUREAU OF MENTAL AND NERVOUS DISEASES.

W. M. BUTLER, Chairman, offered five papers:
*"Influence of Music on the Insane," by C. Spencer Kinney;
"Insanity as a Ground of Divorce," by J. T. Greenleaf;
"Hæmatoma Auris, the Insane Ear," by Amos J. Givens;
"Sulphonal Homœopathically Considered," by F. Percy Jenks;
"Disorders of Digestion in Their Relations to Mental and Nervous Diseases," by W. M. Butler.

BUREAU OF PÆDOLOGY.

(No report.)

BUREAU OF OBSTETRICS.

E. HASBROUCK, in charge, announced two papers:
"Obstetrical Annoyances," by E. H. Wolcott;
"The First Hours of Life," by G. W. Winterburn.

Tuesday evening the members dined together informally in the small dining room of the Delavan House and discussed the attitude of the State Commission in Lunacy to our Middletown State Hospital, also the tenets of homœopathy in relation to our State Medical Examining Board.

SECOND DAY—WEDNESDAY MORNING, 10 A. M.

The COMMITTEE ON PRESIDENT'S ADDRESS reported verbally, through W. M. L. FISKE, that they were unanimous in coinciding with all the suggestions of the President, the effect of which should strengthen and broaden the work of homœopathists as educated scientific men and women.

Our President's formulation of the tenets of homœopathy is a cogent expression, harmonious with the teachings of the Father of Homœopathy himself, and should therefore govern us in our teachings and examinations. The Committee feel that the members of our State Board of Medical Examiners are representative men in homœopathy,

*Read by title.

as well as of this society, and that the question of the tenets of homœopathy, as required by the Attorney General, can and should be left with them.

On motion, the report was accepted.

ROBERT BOOCOCK asked for reinstatement, and was referred to the Board of Censors by the President.

The Secretary moved, in view of the great amount of business to be disposed of, that the reading of papers be limited to fifteen minutes, and the discussions be restricted to ten minutes for each speaker.

Voted.

He also gave notice of an amendment to By-Law V to the above effect.

BUREAU OF GYNÆCOLOGY.

(No Report.)

BUREAU OF SURGERY.

J. M. LEE, chairman, presented five papers:

"A Radical Cure for Retro-Displacements of the Uterus," by F. F. Lehmann;

"How far has the performance of Hysterectomy proven itself to be a justifiable procedure?" by G. C. Jeffery;

"Nephrorrhaphy, with a report of two operations for Movable Kidney," by S. F. Wilcox;

"Cæsarian Section," by H. Willis;

"Anal Spincter Stretching," by W. M. L. Fiske.

The Board of Censors reported, through A. R. Wright, that ROBERT BOOCOCK holds a diploma (M. D.) from the New York Homœopathic Medical College and Hospital and is legally qualified to practice in this state. In regard to a circular which some of the members have seen, it is but justice to all parties that we should mention clearly all the prominent facts bearing upon that. Dr. Boocock declares that it was not his design to issue an advertising circular; he intended simply to make an honest effort to attract attention to a homœopathic dispensary which he was conducting. As soon as he learned that this society disapproved of such methods he took active means to call in the circular, and has promised us that the advertisement shall not again appear. He offers an apology for having permitted the issuance of the literature complained of. We therefore recommend that Dr. Boocock be reinstated to full membership.

On motion the report was adopted and Dr. Boocock was re-instated.

ELECTION OF OFFICERS.

President—WILLIAM M. L. FISKE.
Vice-Presidents—LOUIS A. BULL,
ELMER J. BISSELL,
J. W. CANDEE.
Secretary—JOHN L. MOFFAT.
Treasurer—CHARLES DEADY.
Necrologist—HERBERT D. SCHENCK.

CENSORS.

Southern District—E. HASBROUCK, E. H. PORTER, IRVING TOWNSEND.
Middle District—M. O. TERRY, F. F. LAIRD, J. W. CANDEE.
Eastern District—CHAS. E. JONES, W. E. MILBANK, GEO. E. GORHAM.
Western District—N. M. COLLINS, J. S. HALBERT, G. W. HAYWOOD.

E. HASBROUCK, for the Nominating Committee, presented for the Regents' Degree the names of N. B. Covert, M. W. Van Denburg and Harrison Willis.

T. F. ALLEN—The necessity for the Regents' Degree is past; it is a relic from the old order of things handed down from the other school of practice. This honorary degree was instituted for such men as had gradually worked into and successfully educated themselves for a country practice. The other schools have abandoned it, and we stultify ourselves by continuing the practice. I give notice to amend our By-Laws by striking out Article VI.

The secretary, so instructed by a rising vote, cast the society's ballot for Drs. Covert, Van Denburg and Willis.

The ballot for STATE MEDICAL EXAMINERS resulted in the election of A. R. Wright, W. M. Butler, E. H. Wolcott and H. M. Dearborn.*

The following were then elected the

COMMITTEE TO NOMINATE FOR STATE MEDICAL EXAMINERS:

F. E. Doughty,† Geo. M. Dillow, Edward Chapin, M. E. Graham, Harrison Willis.

On motion of Geo. G. Shelton it was voted to hold the next semi-annual meeting in New York City on October 4th and 5th.

BUREAU OF CLINICAL MEDICINE.

J. M. SCHLEY, in charge, presented a paper on "The remarkable toxic effects of a small dose of Monobromacetanilide."

* The Regents subsequently appointed Drs. Wright and Wolcott.
† Subsequently appointed chairman by President Fiske.

BUREAU OF MATERIA MEDICA.

T. F. ALLEN, chairman: I have had handed me a Proving of Kali Phos. made by a "Provers' Union" in one of our sister states and under the supervision of a well known writer and professor. It consists of an extensive symptom-list arranged according to the Hahnemannian scheme, some symptoms italicized, others starred, etc., but with no indication of which symptoms occurred in the same prover nor of the dose taken. My personal feeling is against publishing such a "proving" as falling short of the requirements of modern science. I therefore offer this resolution:

Resolved, That the Homœopathic Medical Society of the State of New York thanks Dr. H. C. Allen for his valuable contribution "A Proving of Kali Phosphoricum," but feels that the symptoms as there arranged do not sufficiently set forth the effects of the drug nor the manner in which the symptoms were obtained. This society will be gratified if Dr. Allen will kindly amend his paper by substituting the day-books of his provers.

A. B. NORTON, in seconding the resolution, stated that he was informed that the provings under consideration were made with potencies ranging from the 6th to cm., but that most were made from the 12th to the 30th.

The resolution was duly adopted.

T. F. ALLEN then spoke on The Success of Homœopathy as a Science of Therapeutics, (in lieu of a paper).

S. H. TALCOTT: Dr. Allen dwells on calc. carb. for epilepsy in young people. In our experience silicea is better than any other one remedy for young insane persons who have epilepsy. For the immediate relief of spasms we sometimes get good effects from bell. or œnanthe crocata.

W. M. BUTLER: I have had good results with calc. carb., camphor and silicea, but especially with cuprum. It is futile to treat epilepsy on keynote auras, we must get at the underlying dyscrasia.

The President announced that the Executive Board had re-instated NEHEMIAH OSBORNE, of Buffalo, as a full member.

J. M. SCHLEY asked that the Committee on Legislation be given full discretion as to the amount and kind of legislation to be asked for, but that they be requested to obtain the best that can be safely recommended and passed through the legislature. So voted.

STATE MEDICAL EXAMINERS.

H. M. PAINE: I desire to submit for preservation in our *Transactions* the record of the organization and proceedings of the Board, not exactly as a report but as a matter of history.

On motion, so ordered.

J. M. SCHLEY moved that $65.00 be paid Dr. Paine in re-imbursement of his expenses with the thanks of the society for his exertions. Unanimously voted.

Adjourned.

JOHN L. MOFFAT,
Secretary.

RECORD OF PROCEEDINGS HELD IN CONNECTION WITH THE LEGAL ESTABLISHMENT OF THE STATE BOARD OF MEDICAL EXAMINERS. BY H. M. PAINE, M. D., ALBANY, N. Y.

Organization of the State Board of Homœopathic Medical Examiners.

The past year has been memorable in the history of medical legislation in this state, in that there has been inaugurated a system of examinations designed to institute, by means of state examining boards, new and more reliable tests of scholarship, and more uniform standards of medical attainments than any hitherto attempted.

The law creating three state examining and licensing boards, (chapter 507, laws of 1890), according to the provisions thereof, was made legally effective on and after the first day of September, 1891.

In compliance with the provisions of this law the State Homœopathic Medical Society, at its annual meeting held in February, 1891, by ballot selected and transmitted to the Regents of the University a list of fourteen nominees, from which list seven were appointed and were thereby constituted the State Board of Medical Examiners representing the Homœopathic Medical Society of the State of New York.

The names of the members of the board are as follows:

WILLIAM S. SEARLE, M. D., three years.
HORACE M. PAINE, M. D., three years.
ASA S. COUCH, M. D., three years.
JOHN McE. WETMORE, M. D., three years.
JAY W. SHELDON, M. D., two years.
A. R. WRIGHT, M. D., one year.
E. E. SNYDER, one year.

The First Informal Conference of the Three Examining Boards.

At the first *informal* conference of the three examining boards, held in the Senate Chamber at Albany, July 11th, 1891, in compliance with a call issued by the secretary of the Regents of the University, the members qualified by taking the oath of office, and also made other necessary preparation for a more formal and legal meeting, to be held September 1st, 1891. The informal conference of the three boards organized by the election of Dr. William C. Wey, of Elmira, as chairman and Dr. A. R. Wright, of Buffalo, as secretary. On the call of the roll all of the twenty-one members were found to be present except Dr. W. W. Potter, of Buffalo.

The following propositions, suggested by letters and communications received at the office of the Regents, were presented by Secretary Dewey, for consideration and action:

1st. What shall constitute the requirements of a satisfactory preliminary education under the new law?

Decided without a formal vote, that the preliminary education act of 1889, amended in 1890, was sufficiently explicit on this point.

2d. Must all foreign physicians undergo an examination?

Decided, until foreign countries recognize the licenses approved by the state boards of medical examiners of this State and granted by the University of this State, as equal to their own, all foreign applicants for a license must be required to pass an examination before one of the state examining boards.

3d. Must all examinations be conducted in the English language?

Decided: that all examinations shall be conducted in the English language, and that the English language shall be the official language of the state boards of medical examiners.

4th. Can the preparatory courses for medical students furnished by such institutions as Cornell University, Sheffield Scientific School and Johns Hopkins University be considered an equivalent for one year of medical study in an incorporated medical college?

Decided: that medical preparatory courses of study, as such courses are now taught in the various scientific schools and colleges, should not be accepted as an equivalent for one of the three years of medical study required by the law.

5th. Can the fact of graduation from the dental, veterinary or pharmaceutical colleges be considered an equivalent for any part of a three years' course of medical education?

Decided in the negative.

6th. Are such institutions recognized as medical colleges?

Decided in the negative.

7th. What studies will be recognized as a first year's course; a second year's course; a third year's course?

Decided: that this question is one to be determined by the medical colleges themselves.

8th. Will the boards suggest a graded course for the medical coleges?

Decided: that the subject is one over which the boards have no jurisdiction.

9th. Have the boards any power to require an examination at the end of each year of the three years' course to cover the studies of that year?

Decided: that the examining and licensing boards have no legal authority for instituting such examinations.

10th. In other words, must candidates for a license pass all the examinations at the end of each year on the studies pursued during that year?

Decided: that examinations for a license to practice, shall be conducted on all subjects at one time; and that candidates for entrance to these examinations must be graduates in medicine and must have received the degree of Doctor of Medicine.

11th. Ought not a medical syllabus to be compiled, which will show the ground to be covered in each department named in section five of the act; and if so who will compile it?

Decided: that a medical syllabus should be prepared to cover all subjects in which examinations are to be held.

That the medical syllabus shall be prepared by a committee of six, to consist of two members appointed by each board.

That the syllabus shall be the same for all the boards except in the department of therapeutics, practice and materia medica.

That the syllabus committee shall serve as a question board, to revise, unify and correct errors of construction, in order that each question may express its exact meaning and may not be susceptible of a double meaning, thereby securing greater accuracy, directness and definiteness of range.

12th. What number of questions shall be given to each candidate?

Decided: that each question paper shall consist of twenty questions, of which each candidate may cancel five, and be marked on his answers to the remaining fifteen.

13th. When, where and how often shall medical examinations be held?

Decided: that four examinations be held during the coming year, the dates of each to be fixed by the Regents; these examinations to be held in the cities of New York, Albany, Syracuse and Buffalo, and, if necessary, at such other points in the state as there may be a sufficient number of candidates to justify the holding thereof.

It was also decided, that the first formal joint meeting of the three boards, for perfecting a legal organization, should be held on September 1st, 1891, at the Capitol, in the city of Albany. Also, that special meetings of the conference may be held only on the call of the president and secretary thereof, at the request of a joint call by a majority of the members of two of the state boards of medical examiners, when certified by the proper officers of the boards to the president and secretary of the conference.

After the adjournment of the conference, the three boards held separate meetings for the purpose of forming a temporary organization, selecting and designating the different departments to be represented by the members thereof, the appointment of the syllabus committee and for such other business as might be presented for consideration and action.

The First Legal Meeting for Conference of the Three State Examining Boards, held at Albany, September 1st, 1891.

The first legal meeting for conference of the three examining boards was held at Albany, September 1st, 1891. At the meeting Dr. W. C. Wey, of Elmira, was invited to preside, and Dr. A. R. Wright, of Buffalo, was appointed secretary.

The following recommendations were submitted to the Regents for approval:

1st. That a questions committee, composed of six members, two from each board, be appointed, whose duty it shall be, on the call of the Secretary of the University, to convene at Albany, and revise all questions submitted by the individual examiners, under section five of the law.

2d. That a medical syllabus, covering all the subjects in which examinations are to be held, be prepared by the questions committee.

3d. That each question paper on the seven topics, shall consist of fifteen questions, of which the candidate shall be permitted to cancel five, and be marked on his answers to the remaining ten.

4th. That one hundred points shall be the standard, and that each candidate must secure seventy-five in every branch before his or her name shall be recommended to the Regents as a proper person to be licensed to practice medicine in this state.

5th. That the several propositions adopted at the informal meeting held July 11th, relating to the number and dates of examination, and the calling of special meetings be readopted, and continued in force for the coming year.

6th. That at least sixty questions by each examiner in his department, shall be forwarded by registered letter to the Secretary of the University, on or before September 15th, 1891.

The Questions or Syllabus Committee.

The appointment of a committee of six (joint rule 2), to revise all questions submitted by the members of the three boards, was recommended and approved at the joint meeting. The questions committee was also authorized to prepare a syllabus. Drs. J. McE. Wetmore and W. S. Searle, were appointed by the state board of homœopathic medical examiners, to represent that board in the questions committee.

At the same joint meeting the Secretary of the University was authorized to call one or more meetings of the questions committee, the members to convene in a room set apart by the Regents.

The questions committee was instructed to supervise the preparation of all examination papers to be made up from the questions submitted, the committee to have authority to omit such questions as may seem impracticable, unfair or otherwise unsuitable; to restate such as may be obscure or ambiguous. This discretionary power was given to the questions committee in order to secure greater accuracy, clearness and thoroughness; and also so as to accomplish more effectively the great purpose for which the examining boards were created, viz: the *unification and elevation* of the recognized standards of medical educational acquirements. The result will be, the establishment and continued maintenance of a *common standard of excellence*, to which applicants of all schools must conform.

This discretionary power, moreover, is vested in the questions committee, on all subjects other than "therapeutics, practice and materia medica," in which branches the law states that the questions shall be in harmony with the tenets of the school selected by the candidate, "accordingly the two representatives of each board will have sole revision of the questions submitted by the examiners from their board on these topics."

Records of a Special Joint Meeting for Conference of the Three State Examining Boards, held at Albany, January 15, 1892.

A special joint meeting of the three examining boards was held at the Capitol at Albany, January 15, 1892, Dr. Couch being invited to preside and Dr. Lewi acting as secretary.

The subjects presented for consideration and action were the following:

1st. The method and manner of the issuance of circulars, announcements or appeals by either of the examining boards separately.

Called for by the fact that a circular, defining the position, describing the work and embodying an appeal had been issued by the board representing the state medical society, without the concurrence of the members of the two other boards.

Decided: that in future no circular be permitted to be issued by either board except by the approval of the Secretary of the Board of Regents.

2d. May candidates after having failed in a portion of the depart ments, be examined *only* on the subjects in which they primarily failed?

Decided: that candidates, at each examination, must pass an examination in *all* the seven departments, according to the provisions of the law.

3d. Shall candidates be permitted to answer questions in Latin?

Decided: that examinations in Latin shall be conducted *only* by the consent of the presidents of the three boards.

4th. Shall licenses be printed on thick paper or shall a plate be engraved to be used on parchment?

Decided: that the licenses shall hereafter be printed on parchment.

It was also decided, that in addition to the title the officers of each board may be appropriately designated in the license.

5th. Regarding the advisability of appointing a committee to investigate the standards of other state examining boards when licenses issued thereby are presented for indorsement.

Decided: that the secretaries of the three boards be authorized to act as such committee.

6th. Regarding the desirability of vesting in a committee of three or six the power to act on all minor questions likely to arise, thereby avoiding an expenditure of about three hundred dollars required by a full meeting of the three boards.

Decided: that the officers (presidents and secretaries) of the three boards be constituted such executive and advisory committee to render

such aid as may be required in promoting the prompt, effective and impartial administration of the boards of medical examiners in all matters that may be referred to it by the Regents.

7th. The advisability of appointing a committee to act as primary revisors and examiners of all answer papers; referring to the proper examiner such papers only as are doubtful, thereby avoiding delay in making returns.

Decided: that inasmuch as a question arises as to the legality of such delegated power, the opinion of the Attorney-General be obtained.

8th. Regarding the question whether each answer paper shall be marked as a whole or each question separately.

Decided: that each question should be marked separately, *ten* out of every fifteen to be selected by the candidate, and his rating to be fixed by his answers to these.

9th. Is it the part of the boards to bring to the attention of the prosecuting officers any violations of the licensing law?

Decided: that as individuals it would be desirable, but not in a co-operative capacity.

10th. Regarding methods of providing for the payment of current expenses, and as to what constitutes a justifiable expenditure.

Decided: that all expenses incident to attendance upon a joint conference of the three boards; also expenses incurred by committees of the three boards, and by medical examiners, together with postage and stationery accounts, and no others, be paid out of the general fund.

11th. Shall successful candidates be debarred from practice until their licenses are legally and properly indorsed by the examiners?

Decided in the affirmative.

12th. Shall any effort be made to secure a reciprocity with foreign countries regarding the recognition of diplomas and licenses?

Decided in the negative.

13th. Is it advisable at this session of the Legislature to advocate any improvements of or to oppose any interference with the present licensing law?

Decided: that it is not advisable to propose any improvements or changes at the present time. It was also decided that the officers of the three boards (presidents and secretaries), shall constitute the committee on medical legislation.

14th. Shall an examination be re-opened under any circumstances after the answer papers have been handed in?

Decided: that an examination can be re-opened *only* when the Regents and the examiner or examiners who rejected the candidate agree that it should be done.

The joint conference then adjourned to meet in July, on the call of the Secretary of the Board of Regents.

The First Informal Meeting of the State Board of Medical Examiners Representing the Homœopathic Medical Society of the State of New York.

An informal meeting of the members of the State Board of Homœopathic Medical Examiners was held at the Capitol, at Albany, July 11th, 1891. All of the seven members of the board were present. An organization was effected by electing, by ballot, Dr. A. S. Couch president, and Dr. H. M. Paine secretary of the board. Drs. J. McE. Wetmore and W. S. Searle were appointed to represent the board on the syllabus committee.

The departments for examination purposes, selected by the members, and approved by a motion to that effect, embraces the following list:

Dr. A. S. COUCH, pathology and diagnosis.
Dr. H. M. PAINE, anatomy.
Dr. W. S. SEARLE, obstetrics.
Dr. J. McE. WETMORE, chemistry.
Dr. J. W. SHELDON, therapeutics, practice and materia medica.
Dr. A. R. WRIGHT, physiology and hygiene.
Dr. E. E. SNYDER, surgery.

The informal meeting was on motion adjourned to the first day of September, 1891.

The First Legal Meeting of the State Board of Homœopathic Medical Examiners, held at the Capitol, at Albany, September 1st, 1891.

The first meeting for perfecting a legal organization of the Board of Medical Examiners, representing the Homœopathic Medical Society of the State of New York, was held at the Capitol, at Albany, Tuesday, September 1st, 1891. The meeting was called to order by the temporary president of the board, Dr. A. S. Couch. All of the seven members of the board were present.

On motion of Dr. Wetmore, the temporary organization, effected July 11th, 1891, including the officers then elected and the committees then appointed, was confirmed, and the legal organization of the board was thereby perfected.

The minutes of the informal meeting of the board, held July 11th, 1891, and of the full joint meeting of the three boards, held on the same day, were read, amended and approved.

On motion, Dr. Searle was appointed a committee to request the other two boards to unite in holding a joint meeting for the consideration of such subjects as might be presented.

The board then adjourned to meet in general conference; and on reassembling, the officers elected at the first informal meeting were, on motion, continued for the coming year, and Drs. Wetmore and Searle were reappointed to represent the board on the syllabus committee.

On motion, Dr. Paine was appointed a committee to act with similar committees of the other boards, to examine and pass upon the licenses presented by applicants from other states, and to recommend for approval only such as have been granted by States having standards of attainment equal to that required by the laws of this State.

On motion the meeting was adjourned subject to the call of the Secretary of the Regents of the University.

Requirements for the Practice of Medicine and Surgery in the State of New York.

Before any person can legally enter on the practice of medicine in this state, such person must comply with the provisions of laws of 1887, chapter 647; laws of 1889, chapter 468; and laws of 1890, chapters 449, 500 and 507.

The Regents have issued these requirements in the form of blanks to be filled, certified and sworn to by the applicant, and then placed on file in the Regents' office. The blank forms are as follows:

Application to the University of the State of New York for License to Practice Medicine and Surgery.

"I hereby apply for license to practice medicine and surgery in the State of New York, and inclose the following proofs and fee, as required by the laws of 1890, chapter 507, section 8."

1. Certificate of moral character.
2. Required evidence of preliminary education.
3. Required evidence of medical education.

4. Fee of twenty-five dollars, in the form of a draft, post office order or express money order.

Signature of the applicant.

Certificates of Moral Character.

The certificates of moral character, to be signed by not less than two regularly licensed physicians, in good standing, are issued in the following form:

"This certifies that I have been personally acquainted with Dr. —— for —— years; that I know him to be of good moral character, and I hereby recommend him to the Regents of the University as entirely worthy to be licensed to practice medicine and surgery in the State of New York, pursuant to chapter 507, laws of 1890."

The post office address of each signer of this declaration is to be given; also the date of graduation and name of the medical college of which each is a graduate.

Evidence of Having Received a Required Preliminary Education.

The evidence of having received a satisfactory preliminary education defined by the laws of 1889 and 1890, must show that the applicant

Possesses the degree of bachelor or master of arts; of bachelor or master of science; or of bachelor or doctor of philosophy, received by him from a college or university duly authorized to confer the same, or that during or prior to the first year of his medical studies *within this state*, he passed an examination conducted under the authority of the Regents of the University of the State of New York,—in arithmetic, grammar, geography, orthography, American history, English composition, and the elements of natural philosophy, or in their *substantial equivalents* approved by said Regents; or that he possessed qualifications which the Regents considered and accepted as fully equivalent to the above-named qualifications.

These branches are presumed to be equivalent to the studies preliminary to admission to a high-school.

Evidences of Having Received a Required Medical Education.

The blank certificate issued to applicants contains the following questions:

1. "What is your full name?
2. "What is the date of your birth?
3. "What medical credentials (diplomas, licenses or degrees) do you hold? Give the date of each, and the name and location of the institution from which received?

4. "What diploma or license which you have received, conferred on you the full right to practice all the branches of medicine and surgery in the state or county in which it was granted?

5. "How many years did you study medicine previous to the granting of your degree or license to practice?

6. "At what institution and in what year and month did you attend the last course of lectures prior to receiving your diploma or license?

7. "In what months and years and in what institutions have you attended medical lectures? Give the list in chronological order."

Affidavit.

"State of New York, County of ——, ss.

"Dr. —— being duly sworn, says that he is the person referred to in the above application for license to practice medicine and surgery in the State of New York; that the statements therein contained are in his own hand-writing and are strictly true in every respect; that he has complied with all the requirements of the law, and that the provisions of section 6, chapter 647, laws of 1887, as amended by chapter 500, laws of 1890, do not effect his right to receive the license for which he has applied; and that he has read and understands this affidavit and the laws of the State referred to therein."

(Signature of the applicant.)

"Sworn to before me, this —— day of —— 189—."

NOTE.—The law of 1887, chapter 647, section 2, provides:

"No person shall receive the degree of Doctor of Medicine or be licensed to practice physic or surgery in this state unless, after the age of eighteen, he shall have pursued the study of medical science for at least *three* years in a chartered medical school, or with some physician and surgeon duly authorized by law to practice physic or surgery, and shall have attended two (afterward changed to three) complete courses of lectures in some legally incorporated medical school or college in good standing at the time of such attendance, prior to the granting to him or her a diploma or license; provided, further, that two courses of lectures, both of which shall be either begun or completed within the same calender year, shall not satisfy the above requirements."

Law of 1890, chapter 507, section 8, the three-board act, provides that the written application for a license must furnish:

"Satisfactory proof that the applicant is more than twenty-one years of age; is of good moral character; has obtained a competent common school education; and has either received a diploma conferring the degree of Doctor of Medicine from some legally incorporated medical college in the United States, or a diploma or license conferring the full right to practice all the branches of medicine and surgery in some for-

eign country, and has also studied medicine *three* years including *three* courses of lectures in different years in some legally incorporated medical college or colleges prior to the granting of said diploma or foreign license."

This section also provides:

"That applicants examined and licensed by state examining boards of other States, on payment of ten dollars to the University of this State, and on filing in the office of said Regents a copy of said license, certified by the affidavit of the president and secretary of such board; showing also that the standard of acquirements adopted by said state examining board is substantially the same as is provided by section five and six of this act, shall, without further examination, receive from said Regents a license conferring on the holder thereof all the rights and privileges provided by sections eight and nine of this act."

Medical Examinations by the Regents.

In compliance with the resolution adopted at the joint meeting of the three boards, held September 1st, requiring the members within two weeks to furnish the Regents lists of sixty questions, each in his own department, such sets were prepared and forwarded prior to the expiration of the time specified. The series of questions were then submitted to the questions committee by Secretary Dewey, at a meeting thereof, held at Albany late in September. The preparatory work of revising, unifying and perfecting the questions having been satisfactorily completed, the date of the first examination was fixed by Secretary Dewey, and the nine applicants for examination were notified thereof.

Three examinations have been held under the supervision of the Regents.

The *first* examination, held November 10th to 14th, 1891, shows that there were:

Number of candidates,		9
Number refused on account of insufficient educational qualifications,	1	
Number examined,	8	=9
Number approved and licensed,		8

The examinations of the eight candidates were held simultaneously, six at New York and two at Buffalo.

The *second* examination was held January 26th to 29th, 1892:

Number of candidates,		13
Number that withdrew,	4	
Number examined,	9	=13

Number rejected,	- - - -	1
Number approved and licensed,	- -	8= 9

The examinations were held simultaneously, eight in New York and one in Albany.

The *third* examination was held March 15th to 18th, 1892.

Number of candidates,	- - - -	6
Number examined,	- - - - -	6
Number approved and licensed,	- - -	6

The examinations were held simultaneously, four at New York City, one at Albany and one at Syracuse.

A tabulation of these three examinations shows the following results:

Whole number of candidates,	- - -		34
Number insufficiently qualified,	- -	7	
Number that failed to appear,	- - -	4	
Number examined,	- - - -	23	=34
Number examined,	- - - - -		23
Number approved and licensed,	- - -	22	
Number rejected,	- - - -	1	=23

Of the foregoing two were homœopathic applicants; one of these was admitted to an examination and licensed; the other was not admitted, his credentials showing that he had pursued the study of medicine *less* than the required time (three years), and had attended only *two* instead of *three* full courses of medical lectures.

Seven applications for admission to an examination were declined on account of deficient preliminary educational qualifications.

One from the Hahnemann Medical College of Chicago, on account of insufficient medical study, two years instead of three.

One from the Missouri Homœopathic Medical College, of St. Louis, on account of insufficient medical study, two years instead ef three.

Two from the Minnesota State Examining Board, the degree of Doctor of Medicine not being required, and a lower standard than seventy-five per cent. being accepted by that board.

One from the New Jersey State Examining Board, for the same reasons.

One whose diploma had been endorsed by the Western Reserve Medical College, after an examination. (The New York State law provides for the approval of such licenses *only* as are granted by State examining boards, having *substantially the same standard of acquirements* as that established by the Boards of Medical Examiners of the State of New York.)

One from the University of Michigan, on account of insufficient preliminary education.

Sources of Graduation.

NAMES OF INSTITUTIONS.	Number of applicants.	Number accepted.	Number rejected.
Beyrout Medical College, Syria,	1	1	
Trinity University, Toronto, Canada,	1	1	
Toronto School of Medicine, Toronto, Canada,	1	1	
Boston University, Boston, Mass.,	1	1	
Yale University, New Haven, Conn.,	1	1	
University of Vienna, Austria,	1	1	
" Leipzig, Germany,	1	1	
" Heidelberg, Germany,	2	2	
" Cracow, Austria,	1	1	
" Edinburgh, Scotland,	1	1	
" Pennsylvania, Philadelphia,	1	1	
" Jena, Germany,	1	1	
" Naples, Italy,	2	1	1
Dartmouth Medical College,	1	1	
McGill University, Montreal, Canada,	2	2	
Victoria University, Canada,	1	1	
University of Cambridge, England,	1	1	
Harvard Medical School, Boston, Mass.,	1	1	
Med. and Surg. Col. of the State of New Jersey,	1	1	
Eclectic Med. Col. of the City of New York,	1	1	
Total,	23	22	1

Concluding Statements.

While the work which our board has in hand is new and measurably experimental the principle underlying the method of determining medical educational standards, viz: under state supervision and authority, is by no means an untried one. It is in vogue in Canada and in all European countries, where it is well established and is recognized as a far safer conservator of public welfare and more uniformly effective in application than the present system adopted in this country.

The law providing three state boards of medical examiners represents the *principle* for which we struggled—that of divorcing the

teaching from the licensing power and placing it where it properly belongs, under the auspices of the State; hence it affords the best possible opportunity for enabling the profession to attain higher and more nearly uniform standards of medical learning.

The system inaugurated in New York State, however, has this advantage over that of all others in this or any other country, in that while it affords ample protection to the public, it also provides effective means for permitting the three representive schools *separately* to exercise the civil right to conduct, control and complete each under its own supervision, yet under conditions and standards applicable to all alike, its own medical educational affairs. And it is the crowning merit of this perfected system, that the details and entire executive management of this complex method, are placed under the charge of a body of experienced, impartial and unprejudiced educators.

LIBRARY.

REPORT

OF THE

BUREAU OF LARYNGOLOGY AND RHINOLOGY.

"A Case of Intubation," - - - L. A. BULL.
"A Plea for Accurate Symptom-prescribing in Diseases of the Throat, Nose and Lungs," J. B. GARRISON.
"Rhinitis Membranosa," - - - H. WORTHINGTON PAIGE.

A CASE OF INTUBATION.

LOUIS A. BULL, M. D.,

BUFFALO.

Although the treatment of this case did not result successfully, yet it presents some interesting features which seem to me worthy of being reported.

My colleague, Dr. Albertson, called me early in the morning of Friday, Nov. 6th, to see a case that looked like membranous croup.

The history, as he had been able to elicit it when called the night before, was that the child had been hoarse Tuesday night, being awakened quite often by a hoarse, dry cough; Wednesday passed with no particular symptoms additional to the foregoing; Wednesday night he was more troubled with the hoarseness and cough, which did not remit so much as on the night previous. The neighbors were now called in and the child subjected to domestic medication, which included large quantities of syrup of ipecac, kerosene oil externally and internally, large onion poultices and goose grease to the chest. The call to the Doctor, which reached him at 9 P. M., was postponed until the last minute through reasons of financial delicacy. He found the child in a doze, head thrown back, breathing in a stridulous manner and awakened every few minutes by a ringing, brassy cough. There was little or no expectoration. He prescribed the remedies indicated, but no

relief following was called again at midnight. The boy passed a hard night and Dr. Albertson took me with him to answer the early morning call. I found a boy of three and a half years, of scrofulous habit, breathing loud and stridulous about 46 times per minute and with a very irregular pulse of 150. He lay in his mother's arms semi-comatose, pupils somewhat contracted, lips blue, and strong retraction under the clavicles and at the pit of the stomach at each breath. No laryngoscopic examination was attempted, but a careful view of the pharynx revealed nothing out of the way. As much of the chest as could be excavated from the poultice was auscultated but with negative results further than bronchial breathing.

Summing up the case after examination, I was inclined to call it one of laryngismus stridulus. Iodine was given internally, and the steam atomizer, with J. Lewis Smith's formula of oil of eucalyptus, benzoate and bicarbonate of soda, glycerine and lime water in the cup, was kept constantly going. This afforded considerable relief for two hours when the stridor came back as bad as ever. Being called again at 1 P. M., I determined to intubate. So placing the child in position I proceeded to insert the tube. I had merely hooked my forefinger under the epiglottis and had the tube about half way into the larynx, when the pharynx and posterior half of the mouth filled with bright green pus. Withdrawing the instruments instantly I tried to invert the child to allow the pus to be discharged, but the mother who was holding the child with the grip of frenzy, held him bolt upright and the matter partly passed into the œsophagus and partly into the trachea. Thinking that the evacuation of the pus would bring relief without the tube, we waited for half an hour, but insufficient amelioration resulting, a tube was then inserted with the most gratifying results. Still thinking, however, that a short insertion would answer, I did not remove the thread, intending to return in a few hours and remove the tube if it were no longer needed. The thick, tenacious mucus which began to pour up as soon as the tube was in place quickly clotted on the thread and being an annoyance to the boy, his tongue gradually worked the tube up and out, when he was as bad as ever—the flow of mucus stopping as soon as the tube was removed. The tube was replaced at 7 P. M., again greatly relieving; it remained until 9 o'clock when it was coughed up. At half past 10, when I reached him, I found the child very much worse, and it was only after several attempts that the tube could be placed in the larynx, this organ being now nearly closed by a condition of inflammation not present at either of the previous introductions. The tube gave some relief but the child gradually failed until

he died at 5:30 the next morning. No post mortem examination was obtainable and the exact location of the abscess remains unknown; its gradual growth, however, is shown by the three days' history. The steam of the atomizer, which was constantly breathed for five hours, evidently softened it so much that his struggles during the attempt at insertion of the tube caused it to break. I have said that the pus was partly swallowed; this was shown by the fact that a quantity, said by one of the amateur nurses to be half a cupful, was brought up through the tube after its first insertion. A feature of this case was the great quantity of thick, ropy mucus of a gray-brown color which was constantly raised while the tube was in place, stopping instantly when the tube was ejected. Death ensued, I take it, from pneumonia excited by the drawing of pus into the air passages.

A PLEA FOR ACCURATE SYMPTOM PRESCRIBING IN DISEASES OF THE THROAT, NOSE AND LUNGS.

J. B. GARRISON, M. D.,

NEW YORK.

The time we feel the most pride in the law of similia is no doubt when we see a prompt cure follow the administration of a remedy that we have given after a careful analysis of the symptoms, and an equally careful comparison with the recorded pathogenesis of the drugs previously proven.

It is then that we assure ourselves that there is no way to success except by the individualizing of each case, and we no doubt at once resolve to do so ever more. But the next day we are very busy, and having caught a symptom which led our mind to some particular remedy, we prescribe, and instead of the gratifying results of the previous occasion referred to the patient returns with a report of "about the same" possibly, or even the condition may be worse. Then if we do not at once call a halt, and commence to thoroughly study the case we are apt to get deeper in the slough, and finally become helplessly lost. This is at least my own experience, and I only wish I might be sure it would never be repeated.

Those of us who are engaged in work in dispensaries where there

are frequently 40 or 50 patients to be seen in at most two hours would find it next to impossible to individualize each case as it really should be, but would it not be better to see fewer cases there and prescribe more carefully, thereby becoming greater benefactors to the poor, and gaining more knowledge ourselves?

A case of epistaxis came to me from an allopathic family, which school of medicine had exhausted its resources and failed to effect a cure. The source of bleeding was in the right nostril in a small erosion near the junction of the septum with the floor of the cavity, the blood was bright red, the face always became fiery red, and was associated with a throbbing frontal headache. I prescribed bellad.,* five pellets three times a day for one week, and the cure was prompt and effectual. These symptoms have alway led me to prescribe the same remedy and I do not remember a case that has not been cured.

A case of pertussis where the paroxysm always came on suddenly with red face, and blood spurting from the right nostril, was cured by the same remedy in one day, the case being in the full height of the disease.

I only refer to these cases for the purpose of showing that the proper application of the remedy to the case in hand repays us so well for the study necessary, that we should each make our first aim that of being a correct homœopathic prescriber, no matter in what special branch of medicine we may have chosen to work. The occasional cures by remedies we see reported in troubles of the eye, ear, throat, nose and lungs, should stimulate us to try to make it the rule and not the exception that such should be the case, and then we shall have all the more reason to demand our equal rights as physicians, and be proud to call ourselves homœopathic physicians.

DISCUSSION.

M. W. VAN DENBURG: If all our symptomatology was reliable it would be possible to make just as good prescriptions as those reported by Dr. Garrison. The indications upon which he prescribed are standard symptoms which have been repeatedly proved and verified. If failure attends a good prescription the fault is not necessarily and wholly with the prescriber. A large part of it lies in the unreliability of the materia medica. Even Hahnemann's Materia Medica Pura, by Drs. Hughes and Dudgeon, shows this same looseness in detail. Take, for instance, the article on Arsenicum and see how many symptoms are

from the black oxide of arsenic and how many are from the yellow, and how many are from other preparations of arsenic, and how many are from the iodide, and others from preparations we cannot find and of which we know nothing. With such a materia medica one cannot be absolutely sure. We must have some one tell us the origin of the symptoms and their reliability in some degree, or at least to leave us to form some idea of their reliability. We want to know why they are put in there. While much is attributable to carelessness, yet a great many failures may be most justly laid at the threshold of the unreliability of our materia medica.

CHAS. E. TEETS: There seems to be an idea among some of our homœopathic physicians that if a specialist advocates operative treatment he has backslidden and is not a good homœopathist. I think mine is the only clinic in the New York Ophthalmic Hospital that has a copy of the Materia Medica at hand for reference (it may be that the doctors of the other clinics are so well acquainted with the symptomatology of the medicines, that it is not necessary for them to have anything to refresh their memory with), yet I have for the last three years advocated operative treatment in diseases of the throat and nose, because it would be absurd for us to attempt to reduce an hypertrophied or elongated uvula with the homœopathic remedies or to try to relieve an occluded nostril where it was due to a deformity of the septum or abnormal growth. It is our duty first to remove these pathological conditions by operative treatment and then to prescribe for what other symptoms we find in the patient. I speak of this because one of our physicians made the remark that we did so much operative treatment that we should be considered butchers, as the old school are. I believe that on some occasions operative treatment is necessary and that we can operate and still be good homœopathic prescribers.

RHINITIS MEMBRANOSA.

H. WORTHINGTON PAIGE, M. D.,

NEW YORK.

Medical literature treats this disease very meagerly. In only one of several works on diseases of the nose and throat to which I have access do I find anything written of this affection, either as a special disease or as a pathological condition accompanying any other disease.

In the one work in which I did find it mentioned it is rather indefinitely handled as to etiology and treatment, but is well described, except in one point on which I take issue with the writer and will mention later. It is a rare affection, it is true, but not so rare, however, but that the careful observer may now and then see a case at long intervals. In the Throat Department of the New York Opththalmic Hospital one case was treated in 1890 and two cases during the year 1891. In Dr. Malcolm Leal's clinic of that institution I have recently met two cases, one of which is now in my care. In Dr. C. E. Beebe's clinic at the same hospital a well marked case is under treatment at the present writing.

Etiology. Of the causes we know little. Why a case of apparently simple acute rhinitis should assume this fibrinous exudation I do not know. Bosworth claims it is due to a germ, basing his conviction on clinical experience and also on the theory that all croupous deposit is due to some morbid change in secretion from germ presence. Just how clinical observation *convinces* him of the germ cause I do not know, as he admits the laboratory has not as yet described or discovered a germ for this disease. I have personally seen no cases of this affection in the adult. The two cases I have handled were very similarly affected. They were two boys, not brothers, one 7 the other 13 years of age. Were delicate in appearance with a tendency to the strumous diathesis. In both the tonsils were enlarged with moderate chronic catarrhal rhinitis. In these and the two other cases I have seen the nose was naturally thin—the kind of a nose which from its very shape never offers a free passage of air, and becomes completely stenotic from every simple rhinitis. I have thought, might not the morbid fibrinous exudation of rhinitis membranosa be due to the severe pressure exerted upon the puffy infiltration of a naturally simple acute catarrhal rhinitis by confining it in such a narrow nasal cavity, based on some peculiar idiocyncrasy of the patient's strumous habit? The cases I have seen are too few in number for me to any more than surmise this. Whether those who believe a croupous exudation to be caused by the presence of a germ, think that the germ *primarily* causes the symptoms of acute nasal cold that precede the membrane, or that the *acute rhinitis* is the *primary* factor and gives the germ a chance to start a colony I do not know. Suffice it for practical purposes to say that—

Symptoms. The first condition of rhinitis membranosa is that of acute catarrhal rhinitis or nasal cold with malaise, anorexia, and the usual symptoms. Now such cases as a rule do not consult a physician

until the disease is well under way and the nasal stenosis has been annoying them for a day or two. By this time the fibrinous deposit is established. I did not take the temperature in my cases because at the time of the first examination both the patients were feeling so well, barring nasal symptoms, attending school and enjoying play, that it did not seem necessary, and I doubt the presence of more than a degree of fever and possibly none. They had then felt the symptoms four or five days.

Appearance Locally. Local examination revealed the presence of a tough fibrinous membrane about three lines in thickness covering the surface of the middle and inferior turbinated bones and extending well forward into the nasal vestibule, nearly to the cutaneous line. In one case the septum was involved but not in the other, and in fact the deposit is most usually confined to the lateral walls. Owing to the almost complete atresia it was very difficult to make a satisfactory examination of the posterior nasal region from the anterior. From the posterior, however, by means of a reflecting mirror I satisfied myself that the deposit was limited to the anterior portion of the nasal fossæ. The false membrane was covered with thin albuminoid mucus which was oozing out, encrusting the nostril and excoriating the skin of the upper lip. Stenosis was complete, thus preventing proper personal cleansing of the nose. The false membrane when cleaned of the superabundant mucus was white, glistening, very tough and adherent, so much so that free hæmorrhage took place from the denuded membrane underneath whenever it was forcibly detached. On this point I differ with one writer who says that the membrane is *easily* detached *without* hæmorrhage, and makes this his chief point of differentiation between this disease and nasal diphtheria. In the cases I have seen of undoubted membranous rhinitis, detachment was followed by more or less hæmorrhage, and while a mild case with light croupous deposit might not bleed, I still believe this symptom not at all incompatible with this condition or with the diagnosis of membranous rhinitis, and in fact quite the usual thing, and would base my differential diagnosis on other and more important symptoms. It resembles nasal diphtheria, and by the hasty jumper at conclusions might be mistaken for that disease. A careful examination of details will, however, show many decided points of difference. Negatively stated they are: absence of any marked pyrexia or constitutional symptoms; pulse natural, not quick and thready as in diphtheria, and no physical prostration worthy the name. No *acute* glandular involvement. I say *acute*, because in one case, owing to the foundation struma, there was some chronic

induration of the cervical glands, and in view of the diathesis I believe usually present it would not be unusual or suspicious to find this accompaniment—but not acute. The discharge is thin albuminoid mucus, sometimes bloody (if the nose is blown violently enough to detach portions of the membrane) and usually excoriating, evidently more from the constant moisture of its presence than from any acrid character it may possess. This in comparison with the dark, acrid, and many times fœtid discharge of nasal diphtheria. One marked and important diagnostic point of difference of this disease from diphtheria is the location of the false membrane. The latter, in all cases I have observed or heard of in membranous rhinitis, is confined to the anterior two-thirds of the nasal cavity, *not* involving the pharynx or naso-pharyngeal region, and having no accompanying faucial symptoms. I have never seen a case and doubt the occurrence of a case of nasal diphtheria that was not preceded or accompanied by some pharyngeal or faucial lesions characteristic of the disease.

Treatment. Judicious local and internal treatment will show prompt results in mitigation of distressing symptoms and leave the nose in normal condition in from ten days to two weeks. The old school specialists pin their faith to tincture of iron locally and internally. We can do better.

Local Treatment. The indications for local treatment are to destroy and remove the membrane, relieve the distressing stenosis, facilitate free nasal drainage, and protect adjacent surfaces from excoriation. To reduce the engorged and swollen tissues so as to make local applications for the removal of the membrane more effective, as well as to relieve stenosis and promote comfortable breathing, nothing equals the cocaine hydrochlorate in 4% solution. Apply this freely and thoroughly by means of a cotton carrier. It is not readily absorbed owing to presence of the pseudo-membrane, but will ultimately though slowly, permeate to the subjacent tissues and exert its constricting powers on the circulation, thus reducing materially the hypertrophy and permit some degree of comfortable respiration through the nose. After cleansing with cotton, make a thorough application of hydrogen peroxide, using gentle friction in applying it. It is a solvent of this croupous product, and every application reduces it in thickness. I apply it thoroughly several times at a treatment, wiping off the saponaceous product each time. I then again apply thoroughly the solution of cocaine and while parts are still moist from its presence I bathe them freely with a solution of menthol (10 grains to the ounce) in benzoinol, albolene, or glymol. This last has a decided

antiseptic and anæsthetic effect in itself and prolongs the effect of the cocaine, beside acting as a soothing and protective covering for the adjacent surfaces, nostril, lip, &c. This treatment should be carried out daily and the patient supplied with an oil atomizer and the oleomenthol solution, or an ointment of menthol in white vaseline, for frequent use at home.

Constitutional Treatment offers a few very effective remedies. Kali bichromicum gives us the best picture of the condition and is usually the only remedy required. If there is some chronic glandular enlargement and hypertrophied tonsils, mercurius protiodide is most indicated. If a specific taint is present kali iodatum will best do the work. These remedies act most promptly in the first centesimal trituration, given four times daily. The general nutrition must not be neglected and the patient should take cod liver oil in emulsion. This I believe very essential, as it seems to fill nature's want in these and similar cases. Some of the malt preparations might be beneficial, but I put far more faith in cod liver oil as an alterative and tissue builder. The patients with this disease are usually debilitated, and while they may feel fairly well, they look pale and have little appetite. Good nourishing diet and general hygiene are important, and these with cod liver oil and one of the remedies mentioned as indicated, combined with local treatment, will hasten the cure of the local disease. The general condition which favored it may then be brought up to standard by continuing the cod liver oil, care, and diet and persistence in administration of some indicated homœopathic remedy from among the calcareas, barytas, ferrums, arsenics, or sulphurs.

DISCUSSION.

C. E. TEETS: I must take exception to one or two of Dr. Paige's statements. He doubts the existence of nasal diphtheria which was not preceded by a pharyngeal complication. I have had two cases in neither of which was there the slightest invasion of the pharynx. Very little has been written on this subject, although from time to time there has been some discussion in regard to it. Some take the ground that rhinitis membranosa and nasal diphtheria are one and the same disease. I have seen four cases and consider they are two different diseases; it seems to me that a careful observer cannot help but distinguish one from the other. In the first place, in nasal diphtheria

the color is dark grayish while in rhinitis membranosa it is a dirty bluish white. The discharge in diphtheria is always mixed with blood and has a very offensive odor—an odor which is entirely different from the odor of ozœna or syphilis, and an odor from which alone it seems to me that a physician could diagnose a case. In three cases in children whom I was treating for throat trouble, I have been able promptly to diagnose them from diphtheria. In rhinitis there is no odor, as a general thing; the discharge is not bloody; there is little or no fever; while in diphtheria we have a temperature of 100, 102 and sometimes even higher, characterized by elevations co-incident with the extension of the disease and invasion of fresh complications.

M. W. VANDENBURG: How will the Doctor distinguish when one has a patch on the tonsil apparently an exudate, that is white in color, shiny or glistening, tough, very persistent, in patches not more than a quarter of an inch or so across, with scarcely any or no fever?

DR. TEETS: If the membrane could be easily detached I should class it with follicular tonsilitis; but if not then I should believe it to be diphtheria. It has been my experience in most of these cases that if not attended to they eventually degenerate into a special form of malignant diphtheria, and I always make it a point even when the child is playing around and doesn't want to go to bed, to look carefully into the throat and if I see a patch of any description to take that in hand promptly; I instruct the mothers to send at once for a physician should they discover it. I have seen a large number of such cases, and during seven years have lost but three. Another marked difference is length of time the disease runs. I have never been able to cure a case of rhinitis membranosa in four or five weeks, and I have not found such physical prostration as is common in diphtheria.

REPORT

OF THE

BUREAU OF OPHTHALMOLOGY AND OTOLOGY.

"A Comparison of Tests in Heterophoria," - E. J. BISSELL.
"Hyoscyamine Hydrobromate," - - - JOHN L. MOFFAT.
"Electricity in Diseases of the Eye," - - A. B. NORTON.
"Three Cases of Retrobulbar Neuritis," - - C. C. BOYLE.
"A Case of Paralysis of the Eyelids, cured by Agaricus," E. H. LINNELL.

A COMPARISON OF TESTS IN HETEROPHORIA.

E. J. BISSELL, M. D.,

ROCHESTER.

The importance of carefully and correctly estimating any perversion of function of the external ocular muscles is becoming more perfectly and generally appreciated. When searching for the cause of asthenopia or reflex symptoms, an understanding of the condition of these muscles is hardly less important than an accurate measurement of the refraction, although any abnormality of the former is often secondary or dependent upon some error in the latter. The action of these external muscles which so wonderfully brings about the varied movements and positions of the two eyeballs, is as yet not perfectly understood. Possibly, at times, we have been mistaking the normal for the abnormal, or vice versa. There are many interesting questions relating to this subject, but the scope of this paper is very narrow. My aim is simply to make a slight contribution to the study of the comparative value of the two tests most generally used in estimating heterophoria. Two points are to be considered.

First, does the Maddox rod test and the prism test, as used in the various phorometers, give the same estimate of the position which the axes of the two eyes would most easily assume when binocular vision is rendered impossible?

Second, if they give different measurements in heterophoria, which is more correct? From time to time I have read articles extolling the rod test and claiming greater accuracy for it, but I have not seen any real proof in the way of a systematic comparison. Three months ago I began making both tests on some of my private patients and in looking over my case book I find a full record of seventy cases.

At the outset of this work I was confronted by two difficulties First, inaccuracy in the prisms as marked in degrees by the manufacturer. Second, the lack of a suitable card for making both tests quickly, so as not to consume too much time during busy office hours.

The first obstacle was overcome by adopting the new system of designating prisms by prism-dioptres (P. D.) This is not the place to enter upon a discussion of the merits or demerits of the various systems which recently have been suggested. Suffice it to say that the prism-dioptric method is infinitely superior to the old way of designating prisms, and I believe has some advantages over the other new systems which have been offered for adoption.

The second difficulty was overcome by making a card adapted to the use of the prism-dioptres, applicable to both the rod and prism tests, and which would at a glance indicate the character and very nearly the amount of the deviation which the axes of the eyes underwent when diplopia was produced.

The card is 55x69 centimeters and is placed at 5.5 meters from the phorometer or disc containing the glass rod. The scale on the card is therefore made to correspond to the amount of deflection which a ray of light, passing through 1 P. D., would undergo at 5.5 meters. Since 1 P. D., causes a deflection of 1 centimeter at 1 meter distance, at 5.5 meters the deflection would be 5.5 centimeters. This forms the unit of measure as indicated upon the card. I like a large card because when diplopia is produced it gives a better background. The lines forming the scale are 1 centimeter wide and 11 long, and those at the right of the arrow are printed in black and those at the left in red, as in the Prentice test card. A hole 2.5 centimeters in diameter is cut at the center of the arrow. Back of the card is placed a lighted candle or gas jet, so that the flame is directly opposite the hole and near to it. For making the Maddox test I like a glass rod mounted in a small hand magnifying-glass frame. The room is to be slightly darkened and the patient first examined for esophoria and exophoria by both tests. In making the Maddox test the rod is held horizontally before one eye. The flame, which is essential in this test, then appears as a long perpendicular streak of light. The original flame is seen with the

other eye. If the streak of light passes through the flame there is orthophoria of the internal and external recti. If it passes the flame to the side at which the rod is held there is esophoria, if on the opposite side there is exophoria. Since the streak of light crosses the entire card its distance from the flame is quickly determined by the scale above deseribed, thus enabling the oculist to quickly select a prism which will generally neutralize the defect. In testing for hyperphoria the card is turned so as to bring the lines horizontal. The rod is held perpendicularly before one eye and the light *now* appears as a horizontal streak. Its position relative to the center of the flame indicates the amount of hyperphoria. The prism tests are familiar to you all and need not be described. In this test the light color of the card is not essential, but it materially helps many patients, especially those with unequal acuity of vision, to quickly detect the double images. With these explanations I submit the following tabulated cases. As this is simply a comparison of methods all cases were tested under the same conditions, *i. e.*, before a mydriatic was applied or any attempt made at correcting the existing ametropia. As it might be interesting to some to know the acuity of vision and character of the refraction I have stated these in the table.

TABLE* SHOWING A COMPARISON OF ROD AND PRISM TESTS FOR HETEROPHORIA AND ORTHOPHORIA:

No.	EXOPHORIA.			ESOPHORIA.			HYPERPHORIA			ORTHOPHORIA.		VISION.		REFRACTION.				
	Rod.	Prism.	Difference.	Rod.	Prism.	Difference.	Rod.	Prism.	Difference.	Rod.	Prism.	O. D.	O. S.	H.	M.	Ah.	Am.	
1				3.00	50	2.50						20-70	20-70	Md.		Md.		
2				75	75							20-50	20-100			Md.	Md.	
3				1.00	75	25						20-30	20-30	Md.		Sd.		
4				2.00	2.00		2.00	75	1.25			20-100	5-200		Hd.		Md.	
5	75	75										20-20	20-20					Em.
6				2.00	1.00	1.00						20-20	20-20	Sd.		Sd.		
7										0	0	20-20	20-20	Hd.				
8										0	0	20-30	20-30	Md.				
9	1.00	1.00										20-20	20-20	Sd.		Sd.		
10				2.00	1.00	1.00						20-70	20-70	Md.				
11				1.00	1.00							20-70	20-70	Md.		Hd		
12				3.00	2.25	75						20-40	20-30	Sd.		Sd.		
13				1.00	1.00							20-40	20-40		Sd.		Sd.	
14				6.75	4.00	2.75						5-200	8-200		Hd.		Hd.	
15										0	0	20-30	20-30	Sd.				
16				2.00	1.00	1.00						20-20	20-20	Sd.		Sd.		
17										0	0	20-20	20-20	Md.		Sd.		
18	1.00	1.00										20-50	20-30				Sd.	
19										0	0	20-20	20-20	Sd.		Sd.		
20				2.00	2.00							20-30	20-30	Sd.				
21										0	0	4-200	4-200		Hd			
22				1.50	1.50							20-30	20-30			Md.	Md.	
23	3.00	3.00					75	75				20-30	20-20	Md.		Sd.		
24	14.00	12.00	2.00				5.00	5.00				20-30	20-30	Md.		Sd.		
25										0	0	20-100	20-40		Sd.		Sd.	
26										0	0	20-200	20-200		Hd.			
27										0	0	20-20	20-20					Em.
28										0	0	20-20	20-20					Em.
29				2.00	2.00		50	50				20-40	20-40	Sd.		Md.		
30				10.00	7.50	2.50	50	50				20-30	20-30	Md		Sd.		
31										0	0	20-50	20-30		Sd.		Sd.	

32	4.00	0	4.00										20-30	20-30				Sd	
33											0	0	20-70	20-200	Md				Choroiditis.
34				1.75	1.00	75							20-20	20-20	Md		Sd		
35											0	0	20-20	20-20	Sd		Sd		
36				1.50	1.00	50	75	25	50				20-30	20 20	Md		Sd		
37							25	25					20-20	20-20	Sd		Sd		
38				1.00	0	1.00							20-20	20-20	Md				
39	0	1.00	1.00										20-50	20-70	Sd				Amblyopia.
40							50	50					20-20	20-20	Sd				
41							50	50					20-30	20-20	Md		Sd,		
42										0	0		20-200	20-50				Hd	
43				75	75								20-200	20-200	Hd				
44				5.00	3.00	2.00	50	50					20-40	20-30	Md		Md		
45										0	0		20-30	20-30	Md				
46	4.00	1.00	3.00				3.00	1.00	2.00				20-200	8-200		Sd		Hd	
47				3.00	0	3.00							20-20	20-30	Md		Sd		
48	50	0	50										20-20	20-20	Md		Sd		
49				50	50								20-30	20-70	Sd		Md		
50				5 00	5.00								20-30	20-20	Sd		Md		
51				25	25								20-20	20-20	Md				
52										0	0		20-20	20-30	Sd				
53				1.00	1.00								20-20	20-20	Sd		Sd		
54										0	0		20-30	20-50	Sd		Md		
55				6.00	5.00	1.00							20-20	20-20			Sd		
56	5.00	2.00	3.00				2.00	2.00					20-30	20-30	Sd		Md		
57	50	0	50				2.00	2.00					20-200	20-200		Hd		Sd	
58							1.00	1.00					5-200	5-200		Hd		Md	
59				3.00	75	2.25							20-20	20-70	Hd				
60	3.00	75	2.25										20-20	20-20	Md		Sd		
61	75	75					25	25					20-20	20-20	Sd				
62				5.00	3.00	2.00							20-30	20-30	Md		Sd		
63				50	50								20-20	20-20			Sd		
64	50	50											20-20	20-20	Md				
65				1.00	1.00								20-30	20-30	Md		Sd		
66										0	0		20-20	20-20	Sd				
67				3.00	2.00	1.00	50	50					20-30	20-50	Md		Md		
68	5.00	2.00	3.00				5.00	4.00	1.00				20-30	20-20	Sd		Sd		
69				1.00	50	50							20-20	20-20	Sd				
70	1.50	1.50											20-100	20-100		Sd		Hd	

*EXPLANATION OF TABLE.—All measurements were taken at 5.5 meters and are recorded in P. D. (Prism Dioptres.) O. = Orthophoria. In the columns indicating the character of the refraction, Sd. = slight degree (.75 D to .25 D), Md. = moderate degree (1.00 D to 2.00), Hd. = high degree (all above 2.00 D).

	TOTAL.	ROD AND PRISM, SAME RESULT.	ROD AND PRISM, DIFFERENT RESULT.
Orthophoria	18	18	
Exophoria	9	5	4
Exophoria with hyperphoria, x	7	2	5
Esophoria	26	12	14
Esophoria with hyperphoria, 1	6	2	4
Hyperphoria	4	4	
x Hyperphoria with exophoria	7	5	2
1 Hyperphoria with esophoria	6	4	2

Deducting the 18 cases of orthophoria there are 52 cases of heterophoria. In 25 of these cases the rod and prism gave the same result and in 27 a different result, or a little over half of the cases.

In the 27 cases in which there was a difference, ranging from .25 P. D. to 4.00 P. D., the rod test gave the greater deviation except in case No. 39, which was amblyopic. I submit the following reasons why the rod test is more accurate and why it so frequently shows a greater defect:

I. Diplopia is not produced by changing the planes in which the muscles normally work.

II. The images being dissimilar in form there is not as great an effort at fusion. This is shown by the fact that only 4 cases out of 17 cases of hyperphoria showed different results by the two tests; while in the 48 cases of exophoria and esophoria there are 27 cases showing a difference. It being well known that the power of the eyes to fuse images is much greater in the horizontal plane than in the perpendicular.

III. The distance of the streak of light from the flame does not keep changing, as does often the position of the two flames in the prism test. This would indicate that in the rod test the eyes readily assume a position of least strain and that there is little effort at fusion.

IV. The measurements by the rod test seemed to more nearly correspond with the power of abduction and adduction and with the symptoms of which the patients complained.

HYOSCYAMINE HYDROBROMATE.

$C_{17}\ H_{23}\ N\ O_3\ H\ Br.$

JOHN L. MOFFAT, M. D.,
BROOKLYN.

Oculists and their patients are indebted in a marked degree to Dr. N. L. MacBride for his valuable paper presented to this society a year

ago last September* suggesting that, for the purpose of testing refraction, the instillation of a single drop of a one per cent. aqeous solution of hyoscyamine hydrobromate will promptly paralyze the accommodation, even in cases of marked ciliary spasm, and that the effects of this drug pass off more rapidly than do those of atropine.

My experience for the past eleven months corroborates this and relegates atropine (for this purpose) entirely to the background.

Even after the development of a heavy fungous growth, an old solution of hyoscyamine hydrobromate is non-irritating, yet will work. I have not used it in any aged people yet, but have seen no bad effects in patients from 5 to 41 years old. Two patients, who were subject to vertigo spoke of having a little of it during their examination.

In three cases I noticed that the pupil dilated irregularly, being oval at about 75° or 80° with the iris broader in the outer quadrant. The first had compound hyperopic astigmatism, axis 90°; the second, simple hyperopia; and the third showed compound myopic astigmatism, axis 75°. In the first two the pupil became perfectly round with complete dilatation, but in the last—with a history of inflamed eyes—there were posterior synechiæ. In several cases of spasm of the accommodation (equally divided between compound hyperopic and compound myopic astigmatism), although complete mydriasis was observed in about fifteen minutes, the ciliary muscle was not entirely quiescent during the examination; the glasses prescribed, however, afforded the desired relief. In a few instances this incomplete paralysis I ascribed to the patient's jerking the head away and closing the eye forcibly before the drop was well absorbed.

Usually I began testing the refraction about thirty minutes after the instillation, but have been able to do so in some cases in a quarter of an hour. I have prescribed glasses on the fourth day, but more frequently on the fifth or seventh, and sometimes as late as the twelfth. One or two patients complained that the effects of the drug persisted for a week, so I soon ceased predicting that they would be all right in five days but told them to return when the pupils had resumed their former size.

Dr. MacBride calls this drug the hydrobromide of hyoscyamine, but there does not seem to be any warrant for such a hybrid term. The proper name is the hydrobromate, in accordance with the well established rule that "-ic acids form ate -salts." A bromide is a binary compound where the hydrogen of hydrobromic acid has been replaced

* "Hydrobromide of Hyoscyamine," Transactions of N. Y. State Hom. Med. Society, 1890, p. 319.

by an element (as sodium) or a basic radical (as ammonium). Analysis shows that there is no such substitution in the salts of alkaloids. While we are yet in the dark as to the graphic formulæ of alkaloids, we do know the definite amounts of the various elements entering into their composition; we know, for instance, that while there are twenty-three atoms of hydrogen in a molecule of hyoscyamine its hydrobromate has 24; if there were still but twenty-three, there might be ground for calling it the bromide, but even this is more than doubtful.

However, terminology aside, I am glad to add my testimony to the value of this new help in the determination of refraction and to commend it to the consideration of such as have not yet tried it.

> "Be not the first by which the new is tried,
> Nor yet the last to lay the old aside,"

is sound advice for the masses, but there must be some "first" or we would have no progress, and as Dr. MacBride has that honor in this instance it only remains for the rest of us to act upon the second line of the couplet.

DISCUSSION.

CHAS. DEADY: I have used this drug considerably, and cannot agree with Dr. Moffat in one point. I have found disagreeable symptoms. Two patients in my private office were almost immediately seized with a terrible vomiting. Others have had violent vertigo. I would like to ask if the doctor used a fresh preparation?

DR. MOFFAT: No, I was not particular about that. I had a case of incomplete paralysis when my solution was fresh, but the child jerked away its head.

DR. DEADY: We can now have the drug perfectly fresh, as John Wyeth & Bro., of Philadephia, have agreed to manufacture it in disc form. We can thus count on an absolute paresis of accommodation in 30 or 35 minutes, which with the aid of eserin can be made to pass off in 24 hours. This is a great advantage, as many patients will refuse a mydriatic which will not allow them to read for a week.

H. D. SCHENCK: I would corroborate the experience of Dr. Moffat and endorse the paper.

Dr. BISSELL: I think this question of mydriatics is yet far from being settled. I have used for some two years cocaine and homatro-

pine (two per cent. of each), but it has disappointed me; while I find it quite applicable in a number of cases, there are others in which it is insufficient to do the work. I believe that the effect of cocaine in this combination is to aid the absorption of the homatropine; I do not believe it affects the accommodation in the quantity usually administered. I often use eserine afterward, especially if the patient must use the eyes very soon, but the eyes accept the glasses more easily if eserine is not used.

DR. DEADY: Possibly cocaine assists absorption by virtue of its dessicating effect upon the corneal epithelium.

ELECTRICITY IN DISEASES OF THE EYE.

A. B. NORTON, M. D.,
NEW YORK.

The sphere of electricity in eye diseases while at present limited, is, we think, capable of much further extension. The reason of this limitation we believe, lies in the fact that the oculist too little understands the true principles of electricity to try it in diseases where it might be serviceable, while the electro-therapeutist, not having the sufficient number of eye cases necessary to form scientific data, has not the opportunity to give this agency the thorough trial it should receive in order to demonstrate its true value in ocular diseases. It is a generally well recognized fact that all specialists are too limited in their views, and the oculist having a case referred to him with disease of the eye, treats the same in his usual method without stopping to consider whether some other specialist, as for example the neurologist or electro-therapeutist, could not better treat the case than he.

For illustration, take iritis, a disease in which there is thrown out on the posterior surface of the iris an amorphous plastic exudate which serves to bind down the iris to the lens capsule, posterior synechiæ. Now knowing that electricity has great power for causing absorption, why cannot we assume that, if properly applied at the proper time, it would promote the absorption of this exudation in those cases not seen sufficiently early to allow of dilatation with mydriatics before serious damage has been done; and yet ophthalmic literature, so far as my knowledge goes, makes no reference to this having even been tried. The oculist not having that scientific knowledge of the action of elec-

tricity as to the best form and method of application in order to secure a given result, does not give it a trial, or if he does tries it in but a cursory way. It therefore remains for the electro-therapeutist to demonstrate that this and other similar results are feasible and practical.

I am daily becoming more and more convinced of the importance of each physician or specialist knowing *thoroughly* the remedial agencies he attempts to use. In my own department I have seen the vision destroyed in many an eye simply because some physician did not know the effects of a simple solution of lead when there was an ulceration of the cornea, or the fatal consequences of using atropine in glaucoma, etc.

So with electricity in diseases of the eye, while perhaps we are not liable to do so much harm, still from an imperfect use of it we may not obtain the results we should. It therefore seems to me that a more thorough scientific knowledge of the principles of electricity would enable us to extend its sphere of usefulness in the treatment of eye diseases; at present, however, it is of recognized value in a number of conditions.

Commencing with the eyelids, we find electrolysis of the utmost value in the very annoying and obstinate condition of *trichiasis*. In this disease the eyelashes become turned in and coming in constant contact with the eyeball serve to continually irritate the eye, and this irritation may lead to damaging results as to the vision. Epilation gives but temporary relief of the condition and has to be frequently repeated. Plastic operations are not always successful and only usually made when there is complete incurvation of all the lashes. In those partial cases of trichiasis, when only a part of the lashes turn in, electrolysis is the ideal treatment. The use of electrolysis in trichiasis was first suggested by Michel of St. Louis. It is best to use a triangular platinum or gold needle, which is to be inserted into the hair follicle and then connected with the negative pole of an eight to twenty cell battery, while the positive pole is applied to the temple. Minute bubbles of gas appear around the needle and the tissue whitens, when the circuit is closed. The current should be continued for about a minute or until the hair can be removed without resistance. When properly applied the hair-bulb is destroyed and the hair will not grow again.

Angiomata, or vascular tumors of the lid or orbit, are also better removed by electrolysis than by any other method of operation. When the growth is small the negative pole may be applied by a sponge to the temple, but if large, both poles should be attached to platinum

needles two or three inches in length which are then to be inserted into the tumor. The positive needle should remain in one position while the negative may be inserted at different points for a few moments at a time. The first sitting should be brief, and careful notice taken of the reaction, as sometimes a too severe inflammatory reaction occurs. Other growths, even epithelioma, have been destroyed by electrolysis.

Blepharospasm has been successfully treated by galvanism. In this it is best to apply the positive pole behind the mastoid and the negative on the eyelid. In *strictures of the lachrymal duct* electrolysis has been especially advocated by some. We have used it in a great many cases with universally good results; it seems, however, to be particularly adapted to chronic strictures associated with blenorrhœa of the sac. The beneficial results are evidenced by an improvement in the blenorrhœa as well as in the stricture itself. My method of using electrolysis in these cases is to insert the ordinary lachrymal probe in the usual way until it comes in contact with the stricture, then attach the upper end of the probe to the negative pole, holding the positive on the temple, make gradual pressure until the stricture yields. The electrolysis repeated at four or five sittings is usually sufficient to keep the passage permanently opened.

Granular and follicular conjunctivitis. I have seen cases of true trachoma very materially benefited by the use of electricity, while in follicular conjunctivitis I believe all cases that followed the treatment at all regularly were wholly relieved. These cases just referred to, while patients at my clinic at the New York Ophthalmic Hospital a number of years ago, and whose records are not now easily found, were treated by my friend Dr. W. H. King, who at that time kindly treated a large number of cases with electricity to determine somewhat its effect upon various diseases of the eye. The cases of trachoma were treated with the double electrode applied directly to the conjunctiva after the use of cocaine. The follicular cases were treated by puncturing the follicles, which renders the course of such a treatment necessarily long and tedious.

George Lindsay Johnson, of London, describes in the *Archives of Ophthalmology*, Vol. XIX, a new method of operating cases of trachoma by electrolysis, and claims for it very favorable results. His plan is to make incisions parallel to the free border of the lid through the whole breadth of the conjunctiva by means of a three bladed scalpel, the depth of the incisions to be regulated by the swelling or thickening of the conjunctiva. The electrolyser, made of two platinum

blades, is then drawn slowly along the furrows made by the scalpel, all the grooves being taken in turn. He says the best results are obtained by using a current of about thirty milliamperes, and cautions against using a stronger current.

In diseases of the cornea, we find at present only a limited sphere for the use of electricity. The galvanic current has a favorable effect in the rare disease of *neuro-paralytic keratitis*, and as other treatment has proven of but little value in this affection its use should always be tried.

In *corneal ulcers*, especially of the serpiginous and crescentic varieties, the use of the galvano-cautery has proven of great value. Its use in this disease is to destroy the septic material lining the base and side of the ulcer. In using it, the galvano-cautery loop is brought to a red heat, and with the lids opened and the eye steadied with the left hand, the red hot loop is applied directly to the zone of propagation. The eye, previously cocainized, suffers no pain. The resulting eschar is thrown off in about twenty-four hours, and the cornea heals with a less dense macula than under any other mode of treatment. Care should be taken that the patient does not see the cautery before it is applied, as the knowledge that a red hot wire is to be applied to the eye is not generally conducive to the steadiness of the eye. Dr. A. Wirden in 1885 reported the results of 100 cases of ulcers of the cornea treated by the galvano-cautery. In eighty-two cases, but a single application was necessary; in fourteen cases the process had to be repeated after an interval of two days, and in four the cautery was resorted to from three to six times. The average duration of the treatment from the date of the first application of the cautery till the time of resuming work by the patient, was thirteen and a half days. He states that "the results of the treatment frequently surpass all our expectations." By continuing the application of the loop a moment longer, the floor of the ulcer can be perforated when desirable and the hypopyon evacuated.

In *parenchymatous keratitis*, we have found no authentic report of the use of electricity, but as the pathology of this disease shows it to be one of infiltration of round cells into the interstitial layers of the cornea, with a prolifieration of the corneal fixed cells, why can we not expect an absorption of this product by the appropriate use of electricity?

The use of the electro-magnet in removing particles of iron and steel from the eyes, has been very generally adopted by oculists, and many successful cases have been reported. The results as to vision are

always far more favorable if used very soon after the injury. Various magnets have been used for this purpose, that of Hubbell being perhaps the best on account of its size, shape and power. If the particle has penetrated into the interior of the eye, as for example the vitreous, and the wound is still open, it should first be made somewhat larger, so that the foreign body will not be scraped off from the magnet when it is withdrawn; the needle of the magnet is then to be inserted into the wound and as near as possible to the foreign body, which can sometimes be located by the use of the ophthalmoscope. In this way, particles of steel weighing twenty milligrammes have been removed from the vitreous, and the eye recover with perfect central vision.

In *muscular* troubles of the eye we find, however, perhaps the most general and extended use of electricity. Cases of paralysis, both complete and partial, of all the ocular muscles have been restored by this agency. It is usually applied by placing one electrode (some say the positive, and others the negative), over the affected muscle, while the other is placed upon the brow or at the back of the neck; it should be applied regularly every day or two, and from one to three minutes at each sitting. The current should be constant at first, and then interrupted a few times at each application. It should also be used as strong as possible without causing too much discomfort.

In cases of muscular insufficiencies, where we are trying to restore power to the weakened muscle by the systematic exercise with prisms, it is our universal rule to apply electricity for a moment or two after each treatment, and to this use of electricity we attribute much credit in the restoration of the muscular power. It certainly leaves a grateful sensation to the eye when gently used, and often the patient states that the eyes feel rested and stronger after its use.

It has been and is claimed by some that electricity gives beneficial results in various diseases of the lens, choroid, retina, optic nerve, etc., but with these the writer has had no experience, and finds no sufficient accurate evidence to warrant its mention here.

The first extended report of the use of the galvano-cautery in ophthalmic surgery that I have been able to find, was that of Dr. J. Samelsohn, of Cologne, in 1874, who treated with success diseases of the lachrymal sac, trichiasis, blepharitis, trachoma, and tumors of the lids.

DISCUSSION.

E. J. BISSELL: How long does Dr. Norton wait for the application in lachrymal troubles—how frequently are the applications made?

DR. NORTON: I usually have the patient come twice a week to commence with, and then gradually lengthen the interval.

THREE CASES OF RETROBULBAR NEURITIS.

CHARLES C. BOYLE, M. D.,
NEW YORK.

Within a week's time in January I had three cases of what I should call retrobulbar neuritis; they may differ in some ways from the typical type, yet from the history and the appearance I think they belong under this classification. One was that of a young Italian who had lost his sight in the left eye suddenly while playing billiards. V= fingers at 2 feet. On examination, found the pupil dilated much more than the right; it contracted very slightly to the light. Fundus appeared normal; optic disc may have been a trifle pale, otherwise could not distinguish anything abnormal. There was very marked soreness of that eye ball on pressing the eye backwards; complains of the eye feeling large. Field for white very much contracted, for red entirely lost. R. V. $\frac{10}{10}$. The sudden loss of vision, the soreness of the eyeball on pressing it backwards, the trouble being unilateral, loss of vision for red, and the absence of anything in the fundus to account for the trouble, made me make a diagnosis of the retrobulbar neuritis. The cause I was unable to determine: there was no syphilitic history; he drank eight or ten drinks a day, wine, beer and whisky; being an Italian probably more wine and beer than whisky. He did not appear like a heavy drinker; was a cook; may have been due to sudden check of perspiration. The disease was of only two days' duration when I saw him; he did not return for treatment.

The second case was that of a young Swedish girl, who two weeks before my seeing her, suddenly fainted away, when recovered consciousness could not see in either eye, but in a short time the sight of right eye returned, but the left vision remained very dim, but slowly improved; but when I first saw her, two weeks after its occur-

ence it was only $\frac{1}{10}$. The ophthalmoscope showed nothing abnormal in fundus, but there was a decided soreness of the eyeball on pressing it backward. Field for white a little (to 50°) and that for red very much contracted (to 10° and 20°); at some places vision for red seemed entirely lost in the region between the macula and disc. Her menses were normal, but she had nose bleed, and I noticed on the left side a spotted appearance as if the fine capillaries were much congested or broken under the skin; complained of a stiffness of that side of face; physician who sent her said her kidneys were all right. From history, I thought it was probably due to a slight hæmorrhage into the sheath of the optic nerve of the left eye between the chiasma and bulb. I gave patient nux vom.[1] as she complained of feeling worse in morning. In three days returned with vision $\frac{10}{10}$ o. s., field for white trifle larger, but that for red very much improved—very near normal.

The third case is a chronic one. For eight years has noticed that left eye-sight was poor; felt like a vail of eye. Now for one year has had considerable pain over left side of head and in eye, aggravating on using eyes, especially of a dark or stormy day, or at any time when light was dim. Examination of the fundus showed a slightly bluish-white atrophy of optic nerve, with some cupping at upper part of nerve, tension normal, Lv.—$\frac{20}{100}$. Field for white contracted somewhat. Vision for green entirely lost and the field for red very small and in some parts lost entirely, when looking towards right side complained of a spot before eyes all the time, like a vail; this indicated central scotoma. Although there was no specific history, unless it might be hereditary, I gave kal. iod.[1x], for one reason because the pain in head was worse on stormy and dark days—patient has rheumatism. On next visit, said the medicine was like magic on pain in head; have had her under observation for three weeks, and still reports that the pain in head bothers very little, but sight does not improve. I told her that the sight would probably not improve much, but all I hoped to do was to keep it from growing worse.

A CASE OF PARALYSIS OF THE EYE-LIDS, EXHIBITING SOME PECULIAR FEATURES, CURED BY AGARICUS.

E. H. LINNELL, M. D.,
NORWICH, CONN.

Mrs. L——, whose case I am about to narrate, first consulted me May 9th, 1891. She was then 27 years old, had been married two years, but had not been pregnant. She was of an exceedingly nervous and excitable temperament; but with the exception of a "slow fever" at the age of fifteen and occasional attacks of gastralgia, she never remembered to have been sick. Her father and mother, she told me, were very strong and well. One brother had always been delicate, due, she thought, to an injury of the spine when quite young. A sister, also of delicate constitution and never strong, died a few years previously of dysentery; another brother and sister were living and in the enjoyment of good health. Every member of the family, father, mother, brother and sister, was deaf, and her own hearing was considerably impaired in consequence of a chronic otitis media catarrhalis. As stated previously she was of a very nervous temperament, and during the six months prior to the seizure which I shall presently mention, she was more than usually excitable, so that at times, she appeared almost insane, starting at trifling noises and very timid and apprehensive on slight provocation. During this period of unusual excitability she woke on one occasion from an afternoon nap to find herself completely blind in the right eye; this lasted about half an hour, gradually passing off like the lifting of a fog.

In the spring of 1890, just preceding a menstrual period, which was always attended with a good deal of pain, she had a very severe headache, commencing on the vertex and extending over the left side of the head. She had not been a frequent sufferer from headaches, and this one seemed to be almost unendurable, and in the hope of gaining relief she applied freely to the forehead and vertex and to the nape of the neck a liniment that, as she expressed it, "was being passed around." A few hours afterwards her friends noticed that her face was drawn to one side. She retired as usual, and rested well. The following morning there was paralysis of the left side of the face, with lagophthalmos of the left eyelids, paralysis of the tongue, preventing

speech, and ptosis of the right upper lid. The headache continued severe and was attended with distention of the superficial veins of the scalp on the left side, especially of the post-auricular veins. Menstruation commenced and continued as usual in all respects. There was marked twitching of the sound side, especially of the right lids and right side of upper lip. She consulted an old school physician of established reputation, under whose treatment there was marked improvement during the first week, so that she regained the power of speech and the face became nearly natural. Here, however, the improvement ceased in spite of treatment continued for twelve months. The twitching of the muscles continued and she experienced severe neuralgic pains in the distribution of the trigeminus on the right side. The initial headache, it will be remembered, was on the *left* side, but the neuralgia was altogether on the *right*. When she consulted me, in addition to the twitching and the neuralgia there was partial ptosis of the right eye and partial lagophthalmos of the left. The condition, she thought, had remained substantially unchanged since the first week succeeding the initial seizure. The lid could be only partially raised, and she stated that every morning the eye was entirely closed for some time, and that frequently during the day it would become closed for an hour or more, and that at no time during the past year had she been able to open it fully. The left upper lid was retracted, making the palpebral aperture appear much wider than the right. This eye could not be tightly closed, but by a special effort the edges of the lids could be approximated. The left orbit was slightly larger than the right, and on a slightly higher plane, so that the left pupil stood higher than the right, which added to the unsymmetrical appearance of the face. During the neuralgic attacks there was a blurring of the vision of the right eye, which was considerably defective at the best. She said she never had had diplopia. The refraction was as follows: V. O. D.= $\frac{1}{10}$; with— 3.50 ^{dc}, ax. 180°, V.= $\frac{1}{1}$. V. O. S.= $\frac{1}{10}$. The ophthalmoscope revealed a normal condition of each fundus, and the tension of each eye was also normal. The phorometer showed a right hyperphoria of $\frac{1}{2}$°, somewhat to my suprise, as from the apparent position of the left eye upon a higher plane, I expected the reverse. An esophoria of $1\frac{1}{2}$° in accommodation was also observed. I did not make a careful examination of the ears, noting simply a diagnosis of otitis media catarrhalis chronica, and the fact that it was necessary to raise the voice in talking with her.

As before mentioned, the original paralysis came on at the menstrual period, and during the twelve months thereafter she noticed a decided aggravation at such times. Agaricus 6^{x} was prescribed. She came

again after six weeks with the report that she had been nearly free from pain, twitching of lids and blurred vision since the former visit, and on the day before, the right eye had been closed for the first and only time. She had also been free from pain in her ears, and her hearing was slightly better. The movements of the lids now appeared natural. V. O. D.=$\frac{1}{10}$ as before, but—3^{dc} axis 180° now brought it up to $\frac{1}{10}$. Agaricus was continued. I did not see her again until Jan. 26th, 1892, seven months later, when she said: "The second bottle of medicine you gave me cured me. I have had no return of the trouble with my eyes, no drooping of the lids, no blurring of vision, no pain and no twitching." She complained only of slight asthenopic symptoms on using her eyes, due to the astigmatism and heterophoria, for the relief of which she came. V. O. D., then, with—2.5^{dc} ax. 180° ⌐+ 1.5^{dc} ax. 90°=$\frac{1}{10}$ +. A slight hyperopic astigmatism of .5^{dc} was also noticed in left eye. Right hyperphoria of 4° was now found, undoubtedly existing previously in a like degree but latent. Under the use of senega, faradism and the use of prisms it diminished in a few days to 1$\frac{1}{2}$°. She is still under treatment at the time of writing. The increase of visual acuity is perhaps only apparent. Perhaps I did not make as thorough a test of her refraction at first because her eyes were not in a condition to permit of her using them, and I preferred not to give her glasses at that time. It is quite possible, however, that a degree of impaired vision attended the paralytic symptoms, and was induced by the same lesion.

What that lesion was, and where it was situated, has been to me an interesting question, and one I have not been able to answer satisfactorily. Was the connection with menstruation a mere coincidence? I am inclined to differ with the physician first in charge of the case who attributed the attack to the liniment used, whatever that may have been. The coincident paralysis of the hypoglossal, of the seventh on the left side and of the fibers of the third, supplying the levator palpebræ superioris on the right side, while motor spasm and hyperæsthesia existed in the area of distribution of the other branches of the trigeminus could, it seems to me, be caused only by a circumscribed lesion in the vicinity of the nuclei of origin of these nerves. I regret that I did not see the case earlier, and learn more exactly from my own observation the character and symptoms of the initial attack. It seems reasonable to attribute her recovery to the medicine prescribed. After she had remained in statu quo for twelve months, such rapid improvement following its employment must have been more than a mere coincidence.

My attention was directed to agaricus in this case by the record of its successful use in amblyopia, by Dr. Wm. E. Rounds, published in the *Journal of O. O. and L.*, for Jan., 1891. Dr. Rounds' case was somewhat similar to mine, in that his patient was extremely neurotic, the loss of sight was preceded by severe headache and there was present, also, incomplete ptosis of the right eye and much jactitation. In the literature at my command I have not been able to find any record of facial paralysis caused by the drug. It has produced paralysis of the legs in animals, and in fatal cases of poisoning in man, autopsies have demonstrated intense congestion of the brain and meninges, and softening of and sanguineous effusion into the cerebellum. Allen says in his Materia Medica: "Paralysis results as a primary effect of large doses, or as a reaction from prolonged spasm." The paralytic symptoms in the case reported above, therefore, although not found in its pathogenesis, do not counter-indicate its employment. And I am sure no one familiar with the symptomatology of agaricus will question its homœopathicity to every other symptom exhibited by my patient.

REPORT

OF THE

BUREAU OF MENTAL AND NERVOUS DISEASES.

"Influence of Music on the Insane," - - C. SPENCER KINNEY.
"Insanity as a Ground for Divorce," - - - J. T. GREENLEAF.
"Hæmatoma Auris," - - - - - - AMOS J. GIVENS.
"Sulphonal Homœopathically Considered," - F. PERCY JENKS.
"Disorders of Digestion in their Relations to Mental and Nervous Disease," - - - - W. M. BUTLER

INFLUENCE OF MUSIC ON THE INSANE.

C. SPENCER KINNEY, M. D.,
MIDDLETOWN.

We have all heard about the beneficial effects of music, and the impression most of us have regarding its influence is that it is good. So it is, when it can be listened to and appreciated without any unpleasant reaction. What these reactions may be will depend on the predisposing weakness that the individual may possess. Now it is a matter of daily recognition that accustomed environments render us indifferent to noises that would be about unbearable to those unfamiliar with them. Associations of memory may cause certain sounds to disturb tranquility of thought to a degree that sadly interferes with mental self-control.

One can accustom himself to sleep over a station in which the whistling of engines and the moving of trains is continuous, and this noise may become necessary to him in obtaining sleep. To such a person quiet would bring sleeplessness. When we are fatigued physically and mentally we are disturbed by the slighest noise. It is but a step further to consider that the cases of nervous difficulty seen in growing children, as well as those having some form of mental disturbance, are

the result of nerve exhaustion, and consequently these people are susceptible to influences that in health would be easily thrown off.

Now music appeals to the emotions strongly, and when the emotional side of one's nature is thoroughly aroused self-control and judgment play an unimportant part. With those who are insane self-control and judgment must be cultivated by every known method, and any influence that tends to lessen the self-control of an individual suffering with any form of mental disease is an absolute detriment to him. This point will be a difficult one on which to convince ambitious and incredulous relatives, and they will accept it as conclusive only after witnessing results of their own folly. The reason is plain, for we have been taught to believe all the good imaginable to flow from music. Poets have written volumes speaking in praise of music. Sculptors have incorporated into marble their idea of what the muse must resemble, and artists have placed on canvas figures that memory will long take pleasure in recalling. Our own profession has followed along so closely in the path of the poet, the sculptor and the artist, that their tracks coincide, and to the casual observer they represent the footprints of but one.

For the past ten years we have noticed that a certain class of our patients were more restless, excitable or depressed after indulging in music. Attendants have consequently been instructed not to permit patients recovering from an acute attack of mania or melancholia, or any of those who became emotional after playing a musical instrument, to longer indulge in the practice, and to caution them to avoid having anything to do with music. With some this appeared an unwarrantable assumption of authority, and a foolish request, withal. Speaking to a gentleman a short time since of his conversion five years ago to the truth of this theory, he said: "It was difficult for me to recognize the truth of it, and I had to learn it all by a hard experience." Relapses following quickly on violation of this order had a tendency to impress its merit on all patients capable of appreciating cause and effect as related to their case. Those having a love and appreciation of music are the ones who suffer. To the apathetic and those not blest with the musical ear the effect is not marked.

The danger arising from indulgence in music is not limited to the insane by any means, but extends to all who have a strong neurotic taint. This should always be considered in the education of children whose weaknesses may be developed before they take up the responsibility of caring for themselves.

This subject is beginning to attract some attention among those

interested in the treatment of insanity. Dr. Van Deventer, at the last meeting of the Dutch Psychological Society, stated that "music is by no means to be regarded as a harmless form of mental treatment; the factors that come into play are numerous and varied, the use of vocal, instrumental or concerted music, the instrumentation, the tone, musical color, rhythm, subject, harmony and delivery, the time of life and individuality of the hearer, his social status and mental culture and development, and his morbid leanings and disposition, all have to be studied. In all *acute mental* conditions music is contra-indicated, bodily and mental rest being in these conditions of the first importance."

The profession is daily learning the necessity of individualization in the treatment of all diseases.

As to medicines, we have found that aconite, bryonia, belladonna, lachesis and silicea are the most frequently indicated when bad effects have followed indulgence in music.

INSANITY AS A GROUND OF DIVORCE.

J. T. GREENLEAF, M. D.,

OWEGO.

In examining the matter chosen for the subject of this paper it seems to fall naturally into two sections, justice to the sane party and justice to the insane party.

The statute of the State of New York relating to divorce recognizes only one just ground for granting a decree—adultery. The reason for this seems to be that the spirit which prompts to, or permits this sin against conjugal fidelity causes the criminal party to wilfully break the fundamental condition of the original contract, and will sooner or later induce its legitimate and logical train of evils in the form of loss of love for the other party, of interest in the home and its happiness, neglect to provide or care for those to whom the person bears the relation of husband, wife or parent and finally desertion and abandonment.

So sure were the framers of the law that this will occur if the fundamental condition is broken, that it does not wait for these minor miseries to drag their slow length along, but it steps in at once and releases the aggrieved party from his or her part of the broken contract and empowers him or her to renew the bond with some one else

at will. The people who become insane conduct themselves in very nearly the same manner toward the family and home, neglecting the duties laid upon them by the marriage contract, thereby breaking up and destroying the home, and making the situation, needs and demands of one whose husband or wife is insane the same as are those of him or her whose conjugal yoke-fellow has broken the seventh commandment.

As a corollary to the proposition herein treated, may be adduced the fact that in the case of crime the breaker of the law is generally satisfied with simple abandonment and desertion of the wife or husband, while in the case of the insane person he or she not only acts as above stated, but goes on to the offering of violence to those whom he or she should hold in the tenderest of affection and of attempting the murder of the members of their own family.

As far, then, as the sane party is concerned, there is no injustice in granting a decree of divorce; in fact justice would seem to demand that he or she should have the right to collect the fragments of the shattered home and of uniting the family around another who would fulfill the conditions of happiness and prosperity.

Passing on then to the relation of such a decree to the justice which an insane person demands at the hands of those who interpret the law of the land, we are at once confronted by two questions: Are the insane incurable; and, are the insane to be considered criminals, or are they the victims of disease?

A few years ago a large proportion of those whose minds were diseased were considered incurable and finished their darkened existences in the asylum or the almshouse. To-day the increased knowledge of the conditions of cure and the improved means for the speedy and permanent restoration to health make it quite possible to liberate a large proportion of the "souls that are in prison" and regain for them the lost equilibrium of their mental economy, and yet there are some cases that are known from the first to be incurable, and strange to say, the cause of the disease in most of these cases can safely be attributed to conjugal infidelity.

Insane people are the victims of disease, and in the present state of moral science we are unable to judge just how far they are criminals. In dealing with crime and passing upon the justice which should be meted out to the criminal, we are always engaged with the question of the motive, but when we undertake to settle upon what is just to an insane person and to apply to his acts the standard of motive, we can not decide as to how deeply he can examine into the question of

motives in general nor how far any one motive or chain of circumstances will be allowed to influence his conduct, because that part of the human economy which weighs motives and, having weighed, allows them to determine acts or lines of deportment is the part that is diseased and, therefore, the standard and the means of judging being both absent, there is no chance of reaching any reasonable conclusion. In this dilemma we can only take refuge in the decisions of the courts as shown by the treatment which this question receives, as to the final position which the insane are made to occupy, in the estimation of the law, in comparison with the criminal.

Both are placed in confinement and under restraint, the right of suffrage is taken from both, their property is taken from them and the court appoints some one to act in their stead. Both are civilly dead. The criminal is allowed to testify in the courts, the insane person never, because he is deemed incapable of judging of right and wrong, hence, to coin a new phrase, he is morally dead.

Alienists know that insane people are frequently competent to judge clearly on many points of morals or ethics without their minds being influenced by the peculiar form of mental disease which makes them troublesome at home and renders them unsafe persons to be at large, but the law does not make this distinction ; if they are incompetent to judge of right and wrong as to one act they must be the same as to all others, therefore it decrees that they are morally dead.

Insanity differs from other incurable disease in reference to its bearing upon the domestic relations, in that other diseases often allow the victims to perform a part of the duties required by the marriage contract, insanity never.

Many a man has been able to manage his affairs, care for his wife and children and fulfill the duties of husband and father from the chair of the paralytic, and there are many ladies who have administered the affairs of their household, trained and directed their children and so made a home for their family, from the bed of a nervous invalid. Often, in case the malady precludes all physical exertion, the loving and appreciative reception of attention and care, or even the gentle and christian spirit of the incurable invalid is counted the object of the most generous care and the tenderest solicitude for a more active though possibly not more helpful existence.

For obvious reasons the insane invalid is debarred from all such consideration and opportunity and is, therefore, rendered incapable of fulfilling any part of the conditions of the marriage contract.

If, then, an insane person is morally and civilly dead, if the disease

is incurable and renders it impossible for the party to perform any part of the duties required by the marriage contract, it seems to the writer of this paper that granting a decree of divorce in compliance with the request of the sane party does not work any injustice to the insane party; therefore, the above condition of incurability being proved, the applicant should obtain such a decree.

DISCUSSION.

W. M. BUTLER: A great many cases have recovered after having been declared incurable and beyond all hope. One of the worst cases I ever saw in my life had been insane for seven years, and yet recovered. If a law such as is advocated by the essayist should go into effect it would offer an opportunity for the greatest amount of outrage and abuse in the marriage relation that could possibly be imagined. When we get so that we can know the prime factor of the disordered brain it may be time to pass such a law, but in this country with the class of law makers that we have got and the number of changes that are going on in the lunacy laws, such legislation would be very dangerous.

HÆMATOMA AURIS.

AMOS J. GIVENS, M. D.,
STAMFORD, CONN.

Among the rarer affections of the ear is hæmatoma auris, or insane ear, which is a vascular tumor of the auricle caused by effusion of blood or serum between the cartilage and perichondrium, and is usually found in persons with some form of mental disease of long standing. It has, however, been reported in a few cases of acute insanity and in a very few persons of sound mind. It was known to the ancients, as a statue of Hercules in the gallery at Munich has both ears represented as having the disease.

Dr. Farquharson reports a few cases among the boys at Rugby school which were undoubtedly caused by injuries received while playing football. Opinions have been given at different times and some controversy excited as to the cause, whether idiopathic or due to trauma-

tism, and while there is no doubt but that it may be the result of an injury when the morbid condition of the tissues is present, it usually arises spontaneously and is not due to an injury.

The insane ear is of more frequent occurrence in men than in women, and is found in the left a greater number of times than the right ear, but occasionally both are affected; then invariably the swelling commences in the left ear first, probably on account of the common carotid artery being nearer the heart on the left side and the arterial supply to the left side of the head more direct and less impeded.

We see the insane ear in several classes of insanity; in mania, melancholia, general paralysis of the insane, dementia, epilepsy and idiocy; occurring a greater number of times in mania and general paralysis than in any other forms of mental diseases. Of thirty-two patients with hæmatoma who were under the care of Dr. Brown, of West Riding Asylum, England, twenty-four were men and eight were women. In fifteen men the left ear was affected, and in two the right, while in seven both ears had tumors. Of the eight women four had hæmatoma of the left and four of both ears. Seventeen of the thirty-two cases were classified as mania, five as epileptic and eight had general paralysis of the insane, and all were incurable. It will readily be seen that the prognosis is unfavorable in any form of insanity when accompanied with this singular disease.

I will describe three cases of hæmatoma; one with a tumor of the right, one of the left and one with both ears.

Mr. H. was admitted to the Westboro' Insane Hospital in July, 1887. Duration of mental trouble on admission five days. First attack and first admission. Physical health very poor. Has mania and at times is mildly excited; has various delusions. The tumor commenced as a shining bright red enlargement on the anterior surface of the pinna of the right ear, gradually enlarging until the concha was involved, the swelling increasing until the external auditory meatus was closed, and deafness resulted.

The auricle was exceedingly tender and painful, the temperature was increased, the weight caused the ear to stand out from the head and forwards, the anterior wall being much thinner and less resisting than the posterior which contains the cartilage of the ear. Two weeks after it first started the inflammation commenced to subside slowly and the auricle to diminish in size. The tumor became harder, darker and smaller and the fluid contents were absorbed, and at the end of thirty days the ear was contracted and shriveled.

CASE No. 2. Mr. C. H. M. Admitted to Westboro' Insane Hospital December 13, 1886. Male, age 46, single, farmer. First admission. Duration on admission six months. Physical health poor. Form of mental disease, general paralysis of the insane. Has a shuffling gait and walks with great difficulty. Has delusions of grandeur, owns everything about him and has many delusions concerning his past life and work.

The hæmatoma commenced in February, 1887, in the left ear, there being no apparent cause. The tumor was a bluish red color. It was first discovered in the fossa of the helix and swelled rapidly until about the size of a hen's egg and entirely closed the external auditory meatus. He could not lie on his left side or have any one touch the ear, and a sudden jar when walking caused severe pain. After twenty-five days the tumor was opened and discharged freely and the auricle shriveled and contracted.

CASE No. 3. Male, age 67, married, physican. Birthplace, Germany. Form of mental disease, chronic mania. Cause, overwork. Has a great many delusions concerning the nature, density and function of the brain. Very talkative, mildly excited and always displayed a great amount of energy, such as jumping and waltzing when out walking with his attendant. The auricle passed through the usual two stages —first of inflammation, second of contraction—and a few years later he died; no marked change occurring in his mental condition.

In the treatment the tumor should be punctured, the contents evacuated and moderate pressure applied for a few days, followed with massage. With the smaller tumors it is better not to interfere, as the contents will be absorbed about the third or fourth week.

SULPHONAL HOMŒOPATHICALLY CONSIDERED.

F. PERCY JENKS, M. D.
BROOKLYN.

The discoveries of modern chemistry have brought to light therapeutic agents of great power in their action on certain nerve centers.

The reduction of temperature, production of sleep, and the relief of pain are results which are obtained quite certainly by the administration of these remedies in sufficient doses and in suitable cases.

All these benefits are, I fear, obtained at too great a sacrifice, to wit,

loss of force in the cardiac muscle. Better restlessness, sleeplessness, and feverishness, only partially controlled by hydropathy and homœopathic remedies than such symptoms suppressed by antipyrine, acetanalid or sulphonal, as the case may be, at the cost of a weak heart, resulting in prolonged convalescence or perhaps worse; for is it not probable that the unquestioned greater mortality amongst patients under the treatment of practitioners of the other school may have been due to the universal practice of administering cardiac depressants in their attempts to modify the symptoms of the influenza?

Sulphonal owes its existence to the enterprise of the Germans. Professor E. Baumann, of Freiburg, was the first to prepare it. Its hypnotic properties were indisputably established by Professor Kast. Statements asserting its non-toxic action, even in large doses, appearing from time to time, the remedy was brought into great repute as a soporific. Soon accounts of cases in which poisonous effects had been observed began to find their way into the medical periodicals. Doctor R. R. Pettit reported a case in the *Medical News*, in which two doses of fifteen grains each, with an hour and a quarter interval, produced the death of a woman twenty-eight years of age.

A perusal of several cases which showed a similarity in the symptoms resulting from the ingestion of doses which were, whether from the excessive quantity taken or from idiosyncrasy, poisonous to the individual, prompted me to roughly tabulate the symptoms with a view of deriving some benefit from what would seemingly be unmitigated misfortune.

Doctor W. H. Flint, of New York, in an article in the *Therapeutic Gazette*, for January, 1890, states the milder symptoms of poisoning by sulphonal to be fatigue, depression, tinnitus aurium, nausea and marked pallor and œdema beneath the eyelids. He mentions the graver symptoms as diarrhœa, aphasia, and ptosis, a cutaneous eruption like that of rubeola or urticaria, brachycardia, incoördination, semicoma, and collapse.

It is desired in the following to call attention to the mental symptoms and to the effects produced on the nervous system generally. The idea is not to give any fine indications, but to determine whether in this drug we have a remedy which acts strongly on certain nervous centers to which it is desirable to direct drug-action in many cases of disease of the nervous system. This must be determined by our neurologists.

Doctor Stewart, of Montreal, speaks of the ataxic symptoms pro-

duced by large doses of sulphonal, and remarks that they soon pass away.

Four cases of sulphonal poisoning were reported by Doctor A. G. Browning, of Maysville, Ky., in which the following symptoms occurred. In three extreme irritability, in three wakefulness, in three vertigo, in three muscular incoördination and in three mental confusion. Two suffered from nausea, two were sleepy and dull as secondary effects, and two complained of frontal headache. In one case cyanosis, in another tremors, and in a third priapism occurred.

In a case reported by Doctor F. H. Dillingham, a dose of ninety grains produced incoördination, ptosis of the right eyelid, ardor urinæ, vertigo, incoherency, and difficult articulation, the incoördination lasting ten days.

Mr. Hutchinson reported a case in the *Archives of Surgery* in which the patient was so idiotic in demeanor as to deceive him into believing her a non-comp., until he realized his error by a second observation after the effects of the large dose of the drug had worn off, disclosing the fact that he had an unusually intelligent woman to deal with.

Again, a physician having taken a large dose experienced pronounced intoxication, incoördination of first the lower and then the upper extremities. He could not raise a cup of coffee to his lips. He suffered from illusions of having two heads, four feet, and the like, and he believed that he was in a boat or railroad car and that some one wanted to kill him.

These cases are gleanings from sources other than homœopathic. They are not provings. In some cases only one prominent symptom is mentioned, the others which must have been present not having been reported ; but we are able to see that six out of seven experienced mental confusion or incoherency, five out of six had muscular incoördination, four out of five vertigo, three out of five wakefulness, and three had extreme irritability. From the preceding it is evident that the prominent symptoms of sulphonal in the cases cited are:

1st. Mental confusion, incoherency.

2d. Insomnia.

3d. Extreme irritability.

4th. Vertigo.

5th. Muscular incoördination.

The appended table shows the frequency of occurrence of other symptoms.

As regards the use of this remedy, it should be given in accordance with the law of similars. It has been used with success by Doctor

Jeffries, of Boston, in chorea, a disease characterized by muscular incoördination, the aspect of the patient is often idiotic; his dose was five grains. I think the lower triturations would have acted as well.

Vertigo of cerebral origin, cerebellar disease, ataxic symptoms from whatever cause, and chorea, especially if accompanied by the mental symptoms which seem characteristic, would appear to present an appropriate field for the action of the remedy sulphonal.

TABLE.

In the cases quoted above			
Mental confusion, incoherency	occurred	6	times.
Muscular incoördination	"	5	"
Vertigo	"	4	"
Wakefulness	"	3	"
Extreme irritability	"	3	"
Sleepy and dull (secondary)	"	2	"
Frontal headache	"	2	"
Cyanosis	"	1	"
Priapism	"	1	"
Tremors	"	1	"
Ptosis, right eyelid	"	1	"
Ardor urinæ	"	1	"
Difficult articulation	"	1	"
Illusions	"	1	"

DISORDERS OF DIGESTION IN THEIR RELATION TO MENTAL AND NERVOUS DISEASE.

W. M. BUTLER, M. D.
BROOKLYN.

Dyspepsia might almost be styled an American characteristic. From puling infancy to old age, we suffer from this fell disorder. The shelves of our drug stores packed with an endless variety of infant foods for weak baby stomachs, and the no less formidable array of digestives warranted curative in adult indigestion, testify to the universal prevalence of this disease. Yet, upon no function of the body is the general system more dependent for health, than digestion. Supplied with defective material for upbuilding and repair, every

tissue must suffer. Nor is the mischief limited to an insufficient supplying of needed nutriment for repair, as the imperfectly digested contents of the stomach and intestines, while failing to feed, act as an irritant to the impoverished and weakened organism. In no part of the body is this more clearly manifested than in the nervous system. Supplied with such a complex arrangement of nerves and blood vessels any disturbance in the digestive organs must be at once reflected upon the brain and spinal cord. Hence, it is no wonder that so many of the diseases of the nervous system are caused by the reflex influences of disorders of the abdominal cavity. The histories of melancholia, epilepsy, mania and the numerous diseases of the general nervous system, in which reason is not necessarily dethroned, reveal, in nearly every instance, in some part of their course a marked defect in the digestive process.

The mental effect produced by a comfortable condition of the digestive organs has become proverbial, and no one thinks of asking a favor of a hungry man. There is probably no one who has not, at some time, experienced a decided warping of the disposition and clogging of brain action from a temporary fit of indigestion, and this natural irritability, produced by abdominal discomfort, when the source of irritation becomes permanent is almost certain, especially if any predisposition exists, to increase to positive insanity.

Were the pathologists of our insane asylums to limit their researches to the brain alone, the cause of the disease, in many of the worst cases of insanity, would remain shrouded in mystery. Nor is it necessary to await the revelations of the scalpel, as the coated tongue, foul breath, impaired or ravenous appetite and constipated bowels usually proclaim beyond doubt in the early history of the disease the presence of these disorders.

The delusions of the insane also frequently point to these organs as the cause of the disease. Well do we remember one case of melancholia in which for years the poor sufferer insisted that her abdomen was filled with devils. The post-mortem appearances revealed the undoubted presence for years of a chronic peritonitis, producing the direst effects, which in the patient's weakened condition was ascribed to the devil.

The powerful effect produced by diseases of the liver and intestines in melancholia has long since become a maxim in medical history. While modern research does not justify our joining with the ancients in ascribing all cases of melancholia to diseases of the liver or colon, there was undoubtedly much ground for their convictions. Nearly

every case reveals disorders of digestion and in proportion to our success in battling with them will be our probability of cure.

Still more dependent upon the condition of the digestive organs is that dread disease epilepsy. Numerous cases can be recalled by every practitioner, much conversant with the disease, in which the exciting cause has been some indiscretion in eating. Frequently in children predisposed to the disease, gorging of green fruit has brought on spasms, which have developed into epilepsy lasting through life. The ravenous, indiscriminating appetites of all epileptics and the frequent exciting of a series of convulsions by some indiscretion in eating emphasize the ever prevalent irritability of the digestive organs and the close relationship which they sustain to this disease. Utterly futile will be all medicating of epileptics unless, in every case, the quantity and quality of the diet is carefully regulated.

While in mania the digestive organs exert less frequently a causative effect, they are often seriously involved. In many cases the stomach seems proof against anything that can be put into it, and the patient with impunity will eat materials that would kill a sane person. In some cases, however, we find the abdominal viscera directly responsible for the brain disorder. A few years ago we assisted at a post-mortem of one of the worst cases of chronic mania that we have ever seen. This patient, for years, had been the terror of the part of the country in which he resided, and of all the asylums that had been unfortunate enough to be entrusted with his care. During life he boasted of his good appetite and ability to digest anything, revealing no symptoms of disordered digestion; at death no appreciable lesion of the brain was apparent, but the abdominal cavity presented evidences of a long existing peritoneal inflammation, which had involved nearly all the abdominal viscera, and was the undoubted cause of all his mental trouble.

Exclusive of the insane there is a large number of cases of nervous disease, usually classed as neurasthenics, ever dwelling upon the border land of insanity, whose trouble is mainly attributable to disorders of digestion. These are mostly students, professors, professional men,—doctors, lawyers or ministers—and business men, who eat too much, smoke too much, stimulate too extensively, take little or no exercise, and give their digestive organs no time to perform their work. Their symptoms are legion; we find, however, almost invariably sleeplessness, headache, inability to concentrate the mind, often failure of the memory, vertigo, more or less depression, general tremulousness, an inability to perform their ordinary work, numerous imperative concep-

tions and morbid fears as of impending insanity or some serious brain disease.

With these nervous symptoms we find associated a coated tongue, foul breath, constipation and pain in digesting almost any kind of food. Often the most aggravated form of nervous dyspepsia prevails, producing, during the attack, great nervous and mental excitement. We have two of these cases at present under treatment, who, during the paroxysms of abdominal pain, will run up and down the room, throw off all clothing, shriek, cry and evince almost as much mental excitement as a case of mania; yet when free from abdominal distress they are perfectly quiet and sensible and evince scarcely any signs of mental abnormality. The history invariably reveals the story of long abuse of the digestive organs until they have at last rebelled and by degrees brought these sufferers into their present state. These cases are the *bêtenoir* of the physican. If cured it must be by the most careful attention to the regimen of the patient and the most persistent efforts in restoring the weakened powers of the digestive organs; yet, too often they resist all treatment and ultimately swell the army of incurable insane.

The effect of the "rest cure" and feeding in neurasthenia and the different mental diseases, has furnished the most indisputable proof of the influence of the digestive organs in this class of cases. Neglect the digestive organs, and however skillful the medical treatment, in a large proportion of cases the result will be failure.

Still, in the light of these facts, the policy of the New York State Lunacy Commission seems to be to pauperize our State Hospitals and reduce them to the level of the model New York City Asylums, where the officials confess to feeding the patients upon meat which costs four and a half cents per pound while the wild animals of Central Park dine upon meat that costs nine cents per pound. Of what effect do you think the law of similars will be if our insane are to live upon a poor-house bill of fare? How many acute cases do you expect to see cured? If this policy is intended to swell the numbers of chronic insane and pack the wards of our hospitals with incurables it will prove a success. Far better pass a law to shoot each case of acute insanity when the first symptoms appear, rather than starve it into a chronic maniac or hopeless dement.

REPORT

OF THE

BUREAU OF OBSTETRICS.

"Obstetrical Annoyances," - - - E. H. WOLCOTT.
"The First Hours of Life," - - - G. W. WINTERBURN.

OBSTETRICAL ANNOYANCES.

EDWIN H. WOLCOTT, M. D.,
ROCHESTER.

It is the object of this paper to indicate by discussion and the report of interesting, though not extraordinary, cases some of the leading difficulties encountered in obstetrical practice, and to emphasize the treatment that has been most successful in the writer's experience. In the clinical reports, memory has been assisted by the keeping of a memorandum of abnormal conditions occurring during pregnancy, confinement and the puerperal state. The record was made at the time of the visit in a suitable book always carried in the obstetric bag, and thus the facts related are the more correct and reliable.

Let us proceed at once to consider an interesting annoyance commonly called albuminuria, and this not so much for the purpose of discussing it at length—for that seems unnecessary after the appearance of Prof. Danforth's interesting and instructive article upon the subject in the *Homœopathic Journal of Obstetrics* for January—but rather to emphasize a method of treatment calculated to restore, in acute albuminurias, the normal activity of the kidney before confinement occurs.

In some text-books we find this statement: "When there is much œdema of the legs the urine should be tested for albumin." This statement is unsatisfactory and delusive. It ought to read: The urine

should always be examined once in three weeks during the last three months of pregnancy, and every few days when there is œdema, etc. Why wait until the disease is fully developed before we are aware of the fact? Valuable time is thus sacrificed that might have been used to advantage in averting this condition and its oftentimes "unfortunate sequence – eclampsia."

The pathological conditions leading up to albuminuria are often present long before it is possible to notice œdema, and can usually be detected by a chemical and microscopic examination of the urine. A few years ago a patient, then twenty-five years of age, requested me to make an obstetrical visit two or three months hence. According to my usual custom, a twenty-four hour's specimen of the urine was then obtained for analysis. Upon first examination it had a normal reaction. After a time however it was apparent that trouble was approaching, as albumin in large quantities made its appearance in the urine. Later on other symptoms developed, as nervousness, muscular weakness, strabismus, and a peculiar waxy condition of the skin, and finally œdema occurred, but not until the urine had contained albumin for some time. When the albumin was first noticed merc. corr. 3d. was administered every two hours, while occasional doses of bell. and stram. relieved the nervous symptoms. After two or three weeks the albumin and œdema nearly disappeared. The medicines were continued until after confinement when the quantity of albumin remained about the same, the œdema and nervous symptoms being entirely relieved. Had the albumin been unnoticed until the œdema was pronounced, or until the near approach of confinement, it is fair to assume that sufficient time would not have elapsed to have relieved the condition and thereby avert the possible danger of convulsions. The labor, however, was difficult, prolonged and instrumental, the child still-born and imperfectly developed, but the patient fully recovered after four or five weeks. She became pregnant again two years later without albuminuria occurring during the pregnant state, and is now in a delicate condition for the third time.

In November 1891, a Mrs. S. engaged a room at the Rochester Homœopathic Hospital for her confinement, to occur about a month later. When she entered the hospital, the sp. gr. of the urine was 1010, and contained upon examination 0.5% (by weight) of albumin. The microscope did not reveal tube casts or any serious lesion of the kidney. Merc. corr. was at once prescribed and the patient ordered a liberal quantity of Geneva mineral water, which has been of greater service to me than any other water. A day or two before confinement

occurred the sp. gr. was normal and the albumin had entirely disappeared. The labor was natural, the child vigorous, and the mother now enjoys her usual health.

There are numerous remedies suggested in our materia medica for albuminuria, as acon., apis, ars., bell., glon., ver. vir., and others, but merc. corr., in my experience easily ranks first in importance. And although the drug is often prescribed empirically, yet there are well recognized indications for its use. Mitchell says: "It should be given even before albumin appears in the urine, the patient may complain of frequency of micturition and of a scalding sensation before albumin can be detected." It is especially useful when the nephritis has been preceded by a coated tongue, sluggish bowels, thirst, sallow complexion, pain in the back, followed by chill or fever and albuminous urine. In other words, when gastric and hepatic symptoms are first noticed, followed by renal insufficiency.

There are two annoyances at the close of labor that are worthy of our consideration, and this not so much on account of the relationship they oftentimes sustain to each other as cause and effect, but on account of the value of a correct diagnosis as essential to intelligent and successful treatment when they are not so related. Reference is made to post-partum hæmorrhage and syncope. It is easy to understand how the latter can follow as a direct result of the former; but when it occurs from other causes it is not so easily understood or the treatment would be more prompt and effective than hitherto. When either or both of these conditions are present the patient must be examined from time to time to ascertain the amount of blood lost. If hæmorrhage be present it should be controlled as speedily as possible according to well known methods of treatment. But if the face and lips are pale, the pulse feeble, the patient fainting, the external signs of hæmorrhage absent and the uterus firmly contracted, it is evident that the syncope is due, either to exhaustion or cardiac weakness, or at least to causes other than hæmorrhage. This being true, the head should be lowered and stimulants administered at once in moderate doses. With hæmorrhage, however, stimulants are indicated only in desperate cases, and should not be given except as a *dernier resort* to arouse the heart's action. In the absence of either hæmorrhage or syncope, stimulants should not be administered to a woman having just been confined, for in many cases it proves a dangerous remedy. "Nature demands that a woman rest after labor." The vital power, from the feeble circulation, is reduced to the minimum, and nourishment for the time is materially diminished. If, now, the circulation is stimulated, congestion and inflammation are

more liable to occur and fever result. "It is therefore good practice to stimulate only when the circulation becomes so feeble that syncope is inevitable, and then only enough to prevent it. When fainting occurs because the stomach requires food, milk is always a safe article of diet."

Two cases occurring in my practice during the last year, will serve not only to illustrate the foregoing, but will be useful in suggesting other annoyances not particularly referred to in this paper. A patient was confined in September, 1891, with her second labor. Nothing unusual occurred until about an hour after the placenta was delivered, when the patient suddenly fainted, and for more than an hour it seemed impossible to arouse her. There was no external sign of hæmorrhage; the uterus had contracted into a firm, hard ball above the symphysis pubis, and the labor had not been so difficult as to particularly exhaust the patient, yet there was an alarming syncope, and in the absence of other evidence, it must have been caused by cardiac weakness,—a theory entirely consistent with her previous history. The head was lowered, ign. 3d. administered every fifteen minutes, and stimulants given cautiously. After an hour, consciousness was restored, but the patient remained weak and exhausted for several days. On the fifth day she had a chill followed by a temperature of 105° F. My friend, Dr. T. C. White, of Rochester, was called in consultation, and after a careful examination, it was decided that an irritated condition of the left nipple was causing a mammary abscess. This opinion was confirmed in a day or two by a profuse discharge of pus through the nipple, there being no other center of inflammation in the breast. Had the patient known of this abscess at the time, she would have been profoundly affected. The nurse, however, managed to conceal the fact until four or five weeks after confinement. After the abscess ceased discharging the breast gave no further trouble. Meanwhile a very troublesome rash appeared over the entire chest and was so severe in the right breast that a superficial abscess formed and discharged. The rash then disappeared and the patient made a good recovery. The baby was removed from the breast when the chill occurred, and has since grown nicely, and done well on granum and milk.

In November, 1890, a patient twenty-five years of age was confined with her first child. The amnion ruptured at four o'clock in the morning with but slight labor pains. Soon after, they disappeared altogether until ten o'clock in the evening, when they returned and were typical in character. At eight o'clock the following morning, the cervix had dilated to the size of a circle with a diameter of three inches, and the

patient was weak and exhausted. The Hodge forceps were applied, but delivery was difficult and prolonged. The cord was twice around the neck of the child, and nearly caused its suffocation. After a time, circulation was fully restored and the child was doing well. The forceps had made pressure upon the right temple, causing a temporary paralysis of the facial nerve of that side. Immediately upon the resuscitation of the child, it was noticed that the placenta was retained with alarming hæmorrhage. After inserting the hand into the uterus, the placenta was found only partially adherent. It was carefully severed from these attachments; the patient placed in the hæmorrhage position, and thirty minims of the fluid extract of ergot administered for its mechanical effect in contracting the uterus. Hæmorrhage was soon controlled, but the patient remained weak and exhausted for some time. The perineum was partially lacerated, but sutured at once with catgut ligatures. A gradual and uninterrupted recovery was made, notwithstanding so many separate and distinct complications.

The third and last annoyance of which I shall speak is the care of the mammary glands. For convenience of discussion, the following order has been chosen: 1st. What is the best treatment for sore nipples? 2nd. How are caked breasts best resolved? and 3d. How shall the breast be managed when the child is lost?

And before we proceed further, let us consider for a moment the variety of nipples we find in practice, and the particular liability of some of these to disease. The normal or cone-shaped need not detain us. The hollow nipple is especially liable to soreness, for it requires an extra amount of suction to properly empty the glands, and milk accumulates and sours in the depressed portion of the apex; while in the mushroom-shaped, the base is so narrow that the free flow of milk is materially prevented by the grasp of the child's gums. The depressed nipple, sometimes caused by the continued pressure of clothing, differs moreover from all others in that there is no elevation of the nipple above the surface of the breast. Where the nipple should be, there is a corresponding depression, thus making it impossible for the child to nurse. Breasts with this variety of nipple should be firmly bandaged the next day after confinement, and allowed thus to remain for one week.

The treatment of nipples, in general, should be to a large extent preparatory; in many cases, and especially those of a scrofulous nature, the care of the nipples during the latter months of gestation is of great importance. It prevents soreness when the child begins nursing, and thereby diminishes the liability of mastitis and mammary abscess, a

very annoying condition to the patient, and one in which the treatment is anything but satisfactory to the physician. If the nipples are sore and painful, the mother, on this account, will oftentimes prevent the child from properly emptying the glands, and engorgement takes place. After milk has once been secreted, it must be either absorbed or eliminated. When the latter, it will be as normal milk, or changed to that of matter, caused by stagnation and chemical changes taking place in the breast. In this connection it should be remembered that, since sore nipples are usually the cause of mastitis, it is good practice to forego nursing altogether when the nipples persist in soreness and there is considerable inflammation and danger of suppuration. The mother is thereby relieved of the misery arising from persistent and ineffectual attempts at nursing, and the child avoids milk changed in character and diseased by an inflamed and suppurated gland. In some cases, however, the nipple shield answers an excellent purpose. It prevents the usual strain on the nipple, and renders unnecessary the removal, for nursing, of ointments desirable for application during the healing process.

Sore nipples and the resultant inflammation cannot always be prevented with even the most careful and scientific treatment, yet a large number of cases is averted, doubtless, by proper care of the nipples previous to confinement, unless there be gross negligence during the first few days of the lying-in period. For two months before delivery the nipples should receive a daily bath of cold water to accustom them to cold, and to prepare the breast for the usual exposure incident to lactation. A systematic effort should also be made to harden, toughen and give endurance to the nipple, both by local and internal medication. Prof. Burdick's prescription of sulphur, tannic acid, borax and glycerine, when mixed in varying proportions, according to special cases, and applied every night, acts kindly in removing irritability, and in strengthening the integument for the strain of nursing. In many cases however, the internal administration of remedies is the best treatment and all that is required, especially if they are carefully selected with special reference to the etiology of the diseased condition. Among the more prominent drugs, the following deserve to be mentioned: sulphur, graphites, silicea, calc. carb., lycopodium, phytolacca, hepar, rhus tox., merc. corr. and sepia.

When the breasts are caked, they are best resolved by means intended to bring about the desired result with the least amount of friction and injury to the glands. The breasts should be carefully rubbed toward the nipple with warm dulcamara or phytolacca ointment,

bry. 3 or phytol. 1 internally administered, and the Mother's Friend Breast Pump applied thoroughly every two hours until any danger from abscess has passed, and the breasts are in normal condition. The pump just referred to has advantages over any other on the market. It is inexpensive; can be used by the mother as well as by the nurse, and does not irritate or injure the milk-ducts, or any portion of the glands. Should there be history of breast abscess, or should the child be still-born, the breasts should be thoroughly bandaged the next day after confinement and kept in that condition for one week. For this purpose the figure-of-eight bandage of the chest is the most desirable, and is described in the International Surgery.

Should there be galactorrhœa, or should the child die after having nursed for some time, the double Y bandage, first used in the Boston Lying-in Hospital, will be found of the greatest service. It is thus described by Dr. Worcester: "A single T bandage is first made by folding a napkin lengthwise so that, for an average sized patient, it shall be 32 inches long by 3 inches wide. At the middle of this, and at right angles to it, is pinned, just between the folds, a napkin of the same size, similarly folded. This T bandage is next made into a Y bandage by making a diagonal fold in the middle of the cross-piece, and fastening the corners of the plait with safety pins on the outside. The tail piece is passed under the woman's back, swung up to her arm pits so that the fork of the Y just clears one nipple, when that breast is held upward and inward on the chest. The tail piece on the other side is carried up on the chest directly over the breast. The arms of the Y are then brought over the chest, one above the other, below the breast, and their ends pinned to the tail piece so as to hold both breasts in a similar position. A compress of soft linen may be placed between the bandage and the outside of the breasts to prevent their chafing. To keep the bandage from slipping down, straps of muslin may be passed over the shoulders and pinned back and front; to keep it from slipping up, it may be fastened to the abdominal bandage." This bandage has several advantages: It does not require removal should it be necessary to use the breast pump; it exercises a constant and uniform pressure over the glands, thereby lessening the amount of secretion and affording opportunity for the gradual elimination of whatever milk does accumulate by the exposure of the nipple; and can easily be removed temporarily should it be desirable to apply ointments to resolve the breasts when caked, or to assist in drying up the milk.

A patient thirty-five years of age and of scrofulous habit was con-

fined with her second child August 3d, 1886. As there had been some irritation of the nipple after the first confinement, Dr. Burdick's prescription, referred to, was used during the last two months of this pregnancy, and sulph. 6 administered internally. Notwithstanding this treatment, the nipples were sore and irritable when the child began nursing. The child at birth was cyanosed, and on this account never had sufficient strength to properly empty the glands. The nipples persisted in being sore, and at the end of the first month an abscess developed which required lancing several times before the inflammation and suppuration ceased. The other breast was used for two months longer, when the child died of whooping cough. When the third child was born (May 13th, 1890) the breast with the history of abscess was firmly bandaged the day after confinement and kept in this condition for eight days. Upon the removal of the bandage the breast was entirely free from milk, and it gave us no further trouble. The child nursed from the other breast for a week longer, but the nipple persisted in being sore and nursing therefore was abandoned altogether, fearing the irritation would cause another abscess. The pump was applied for a short time, when all milk disappeared.

Clara C. (colored) entered the Rochester Homœopathic Hospital October 15th, 1891, and was confined November 7th. Labor continued seventeen hours, at the end of which time she gave birth to a female child, and an hour later to a male child. The placenta soon followed, and the patient was in good condition. Only one of the twins nursed well, and on the 11th the breast filled so rapidly, became so hard and contained such an abundance of milk that it was deemed necessary to thoroughly rub them with camphorated oil three times a day, apply the double Y bandage, and use the Mother's Friend Breast Pump every two hours in connection with the nursing. Meanwhile the secretion was so great as to saturate the clothing about the chest, and still enough milk remained for the infants. August 13th, the breasts were still somewhat hard and the bandage was retained. Nov. 16th, the bandage was removed, both breasts being normal. The patient nursed both babies for the next month, when she was discharged from the hospital. A few days later, it was noticed in a morning paper that she had left the twins on a door-step to the tender mercies of a bachelor friend, and herself departed for the city of "salt."

DISCUSSION.

Dr. M. W. VAN DENBURG: I have found dentists' sheet rubber a most excellent auxiliary in bandaging or supporting the breasts. With it one can make pressure as firmly as is desired, and I have seen considerable hardness disappear in twenty-four hours, for it will heat and leave the breasts in a moist, sweaty condition.

THE FIRST HOURS OF LIFE.

GEORGE W. WINTERBURN, PHAR. D., M. D.,
NEW YORK.

The topic on which I have chosen to speak to-day might be approached from many points of view. In the first place, it would be very interesting to consider it from the psychological standpoint, and to try to ascertain how the earliest impressions of external existence affect the mind of the newborn. Were we to follow the lead of materialists like Huxley, and look upon thought as a mere secretion of neural tissue, then, indeed, a new born child would not be of much interest to the psychologist. But if we believe, and I am glad to record myself as among those who do so believe, that man is something more than a combination of hydrogen, oxygen, carbon and nitrogen, then there is a psychic life which antedates birth and continues on beyond death.

I am satisfied, as the result of many years' careful study of the newborn, that the psychic life is much more active in them than is commonly supposed. That not only does the fœtus experience sensations, not only is it convulsed by conflicting emotions, but that it has something near akin to thought, and that it issues into contact with the outer world, having already passed through psychic experiences which will mold all its future. To the careless observer the babe seems to know nothing, simply because it has not yet learned to convey to others an intelligible explanation of its capacity for sensation and emotion. It seems an unthinking mass of tissue. But its powers are vastly underrated. It is on the mental and spiritual level of the brute creation. Who has not noticed the wonderful sympathy and capacity

for understanding each other that exist between a dog, for instance, and a very young child; and we, in proud consciousness of our own superiority, look down smilingly on both. We call the dog and his congeners dumb brutes, but the dumbness is on our part as well as on theirs.

Interesting, nay alluring, as it might be to discuss fully the first experiences of life from a psychological, or a sociological, or from an anthropological standpoint, I do not forget that I appear here not as a student of mind, or of social theories, or of man in the abstract, but as a practical obstetrician, and that we are met together in this bureau for mutual aid in our work in midwifery, and not at all for the purpose of exploiting excursions into other realms of thought, no matter how practically useful these might be made. Nevertheless, midwifery practice would probably have been much less delightful to me than it has been if I had not brought to it so sincere an interest in all that concerns human welfare. *Homo sum; humani nihil a me alienum puto* is the inherent impulse of every broadening mind.

The duty of the obstetrician to the new born is then my theme. We hear a great deal about the care of the mother, and this is right, and very little about the care of the child, and this is wrong; the child's side of the question has been almost entirely neglected. Let us, then, in imagination approach the parturient bed. The child has this moment been born into the world by that powerful downward thrust —which Haughton has shown may exceed five hundred pounds*—of the fundial muscle, assisted by the abdominal parietes, and lies gasping for life between the maternal thighs. With that first wailing cry, which seems a protest at being thus summarily forced into an existence of which it knows nothing but may reasonably fear much, it takes up the current of individual life. The essential outcome of that life, as far as material existence is concerned, and the reaction of this on the spiritual nature, is much more dependent upon the accoucheur than he usually recognizes. The babe has been sheltered until now, within the maternal tissues, from rude contact with physical forces which now assail it in every direction, as if to test its powers of endurance, as indeed they do. The experiences which it has had have filtered to it through the mother's heart and brain, with such more direct ones as have come to it by contact with a smooth surrounding membrane

* "On the Muscular Forces employed in Parturition; their Amount and Mode of Application," by Rev. Samuel Haughton, M. D., in *The Dublin Quarterly Journal of Medical Sciences*, May, 1870.

buoyed out by amniotic fluid. These experiences have but barely fitted it to cope with the rude forces of light and heat, and physical contact with the alien objects to which it is now suddenly exposed. When we consider into what a maelstrom of assailant and abhorrent forces it is plunged we cease to wonder that babies sometimes die; the marvel is that any survive.

The first point of criticism which I would make is that the babe is not handled with sufficient delicacy. It certainly is evident that its new conditions should be made to resemble, as far as possible, the ones to which it has been accustomed; it should be inured to its new phase of life as gradually and gently as possible. We have become ourselves, through oft-repeated harsh experiences, so used to heat and cold, light and noise, that we do not realize what powerful stimulants they are, what exquisite pain they must inflict on one who is unaccustomed to them. Our crass obliviousness is, however, no protection to the child. He suffers; and suffers just as truly as if the reasoning powers were developed, and he could analyze, describe and formulate the causes of his pain. It is not necessary to comprehend the effect of a thing in order to be its victim.

If the effects of roughness were but temporary, this criticism might seem frivolous—an undue, finical refinement. But they are not temporary, but outlast life itself, and are visited upon the third and fourth generation of their victim's descendants. Nervous disorders which greatly modify the usefulness and pleasure of life, and even more obvious lesions, such as hip disease, have their frequent origin in the rough handling which children receive during the first hours of life. Treatment which, even a few days later, might be borne without injury, because the system so soon adjusts itself to surrounding conditions, is now productive of irreparable mischief, which, unhappily does not kill, but only maims. Careful observation leads me to fear that many of the miseries of life, and not infrequently the sources of crime, have their origin in the ignorance and carelessness which, permit sad ravages in the neural tissues at this most sensitive stage of the child's existence. I am leaving out of sight now all the possibilities of danger which the child encounters on its short but tragic journey down the vaginal canal, and the resultant injuries and deformities which occur from carelessness on the part of the attendant. I use the word carelessness in its generic sense. A careless [Latin, *curo*] is one who fails to cure, who lets the golden moment of opportunity slip by unheeded. The obstetrical forceps, in unskilled hands, is the deadly enemy of the child, and is a not infrequent cause of nervous disorders

from the crushing of brain tissue, especially when used on the after-coming head. Again fractures of the skull are occasioned by unskillful manipulation, resulting in either intellectual or physical deterioration. Brachial palsies result from awkward and boisterous attempts at extracting the shoulders; thrombi, most frequently in sterno-cleido-muscle, may occur anywhere, from rough handling. Fracture of the neck and fractures and dislocations of the limbs, and many other so called accidents occur, when the practitioner is too hurried or too obtuse to avoid them.

These, however, are incidents of the second stage of labor, a time antecedent to even the first hour of life in the meaning of our text. We have to do here solely with the duty of the accoucheur to the child already born. It is, perhaps, a great deal to ask of the tired doctor who, after hours of strenuous exertion, hears at last that wailing cry which brings joy to all but its utterer, to be alert to the thought that in his hands he holds embodied the future of a soul, who, whatever may be its intrinsic worth, has as yet so feeble a hold on material things as to be more helpless than any other living creature. And yet upon his wise foresight hang all the issues of that life, and upon him is laid, therefore, a grave responsibility which he may not shirk nor neglect, upon his honor, no matter how tired or worn he may himself be.

It is obvious that the less a new born child is handled, the less likely it is to be injured. The experiments which have been made by Dr. Louis Robinson, of London, and detailed in his articles, "Are Babies Like Monkeys" and "Darwinism in the Nursery," in which the attempt is made to prove that young human infants have certain simian qualities, are interesting, but they hardly improved the chances of health of those upon whom the experiments were tried. Everyone knows that a human being, of any age, can stand a certain, indeterminable amount of exposure without evincing any immediate evil results. But that the sinister quality of the effect of such exposure is not at once evident does not prove that the result is not evil. All surgeons know that the peculiar condition of the spinal cord known as "railroad spine" is not proportionate to the apparent amount of injury at the time of the accident. The patient may have seemed to have escaped with only superficial lacerations of the peripheral tissues, and yet, months after, develop a very serious spinal lesion. The experiments of Dr. Robinson on 150 babies, some of them born within an hour or two, some a few days old, consisted in inducing them to cling with their tiny hands to a stick or a branch of a tree until they fell from

exhaustion. Some thus supported their entire weight for two minutes and a half, others gave up the struggle at the end of ten seconds. This seems to prove nothing but that the power of the newborn to sustain themselves by muscular exertion is a very variable quality, but we will let the doctor speak for himself: "The actual discoveries these experiments led to are these: that every newborn child, unless it is sickly or otherwise imperfectly developed, has a most wonderful power in the flexor muscles of the forearm, and will support the whole weight of its body, during the first few hours after birth, for a period varying from ten seconds to two minutes and a half. Now everybody knows that in monkeys the power of grip is very fully developed; quadrumana can do anything with their hands and arms, and in case of danger this power is a chief means of self-preservation. It is curious that it never occurred to Darwin to try this experiment. But before I go further into the subject, let me say at once that my experiments were undertaken not to prove anything, but simply to get at a knowledge of the facts and to see where the facts led to. I have not much claim to call myself a scientist; I only appear as a witness, putting forward the facts and leaving them to be judged by those whose special knowledge of development, anthropology and evolution fits them to judge of the value and bearing of the evidence I have gathered. The investigations have been my recreation only, and this must be my excuse for their very fragmentary and imperfect character." It is quite possible that all these 150 babies experimented upon by Dr. Robinson came through the ordeal without damage, but when we take into consideration the delicacy of the tissues of the newborn's body we cannot but feel that a grave responsibility was assumed, and that he had better have taken his recreation some other way. For after all the experimentation only proved what any old granny could have told him, that infants have considerable grip, and that it varies very greatly in different children.

But there are more common sources of danger to the newborn than the jejune curiosity of the amateur evolutionist. The absurd habit of making an elaborate toilet and dressing the babe in flounced and embroidered dresses is, I hope, somewhat declining. The child has just been through one of the severest conflicts of life and needs repose, not washing. To trick it out with all the arts of millinery, and hand it about for inspection among its forbears, its sisters, cousins, and aunts, is not only folly, but a refinement of cruelty, or perhaps I had better say a cruelty of refinement, which no doctor should permit.

A proper course of procedure may thus be described: The cord

should not be cut until it is pulseless and cold; this is to save every drop of blood to the child possible; it needs it all—it has only twelve ounces of it at best. The child should meanwhile be protected from the air as much as possible by being covered by a small blanket, as the air of the parturient chamber at 70° F. is as cold to it as one at 35° would be to us; and none of us would find it pleasant to remain nude in a room at this latter temperature. Although every means should be used to prevent loss of body temperature, the child should be encouraged to cry vigorously. Many infants will give two or three feeble cries and then doze off, but this should not be permitted. It is of the greatest importance that the whole lung tissue should be brought into the fullest possible action, and if the infant shows any indisposition to do this, I quickly wrap the cord in a heated flannel, which has been previously provided against such an accident, so as to maintain the circulation (sometimes for fifteen to twenty minutes), and, at the same time, encourage respiration by tickling the child on the sides of the chest under the arms; this usually sets up reflex action and vigorous inspiration. If this does not cause a quick response, gentle friction at the base of the brain will help, or the hand, held in cold water and then applied along the anterior edge of the diaphragm will, as far as my experience extends, always produce the desired response.

When the cord is cut the babe is gently lifted into a receptacle which has been prepared for it, on a table, or lounge, or crib, near by. This consists of sheets of cotton-wool—usually three bundles will be required—laid out smoothy on a flannel blanket or eider-down quilt. These have all previously been thoroughly baked, and if there is plenty of service, are kept warm (about 110° F.) until needed. Laid nude on this soft couch, the edges of which are brought up deftly about the little form, and tucked in, enveloping it completely, including the head, an aperture for breathing being alone left, the babe is comfortable and safe. A small, soft napkin, generally an old table napkin is to be preferred—this also having been made hot—is placed under the buttocks to catch the discharges. The crib, or whatever the child may be lying upon—I prefer a small table, if possible—is then drawn to the warmest part of the room, and the child is allowed to sleep for twelve hours. If the child is born during the afternoon or evening, it is not washed until the next morning; if born during the night or early morning, it is washed in the evening; and I always endeavor to be present at the first bath, which I consider a very important ceremony. It is preceded by a thorough inunction with warm lard—usually from one-half to one pound is used *pro re nata*—rubbed slowly into the tissues, the nurse, if

possible, sitting facing a good grate fire and holding the child in her lap. The child is then immersed in warm suds made from Ivory soap, and rubbed gently, but sufficiently to free all the pores; then into a clear warm bath at a temperature of about 115° F. to remove the suds; and then back to the nurse's lap, on which is spread a dry blanket, in which the babe is enveloped; it is then dressed, simply and warmly.

The mother does not usually see the child until after its bath, and, under no circumstances which can be anticipated is anyone allowed to disturb the child during sleep. If it awakens, simply turning it on the other side, the nurse holding her hand softly on the upturned shoulder, is sufficient to cause the baby to resume its sleep. The head should always be turned fully on to one side or the other, the weight resting on the ear, never on the occiput. To allow the head to rest on the occiput is to invite tetanus. After the bath the child is put to the breast, being, during the process of suckling and at all times, diligently shielded from the cold, and after a few minutes is returned to its crib. Under no circumstances is it allowed to remain in the bed with the mother; if no better contrivance is available, it is snugly wrapped and laid on a table drawn up near the fire. A baby so treated will, on the average, wake up once in two and a half hours, and may then be put to the breast for a few minutes. As a rule, the baby will sleep ninety-two hours out of the first one hundred. It will generally be wakeful, and somewhat fretful, at the recurring hour of the day at which it was born; that is, a babe whose birth occurred at 2 o'clock, A. M., will be likely to give more trouble to the nurse in the hour two to three than at any other part of the twenty-four. This is more certain if the child is born during a rising tide, or at its culmination; a child born at ebb-tide will be quieter, but also more feeble. Children born during the last quarter of the moon are more prone to little ailments than if born three or four days after new moon. These facts I record as a matter of personal experience and observation.

How much of the actual success I have had in these cases is due to the careful provision I make for enforcement of this regimen immediately after birth, and how much is due to prevision by carefully meeting every abnormal symptom in the mother by its drug-similar before the birth, I am unable to determine. I believe that very much can be done for the child, while yet it is in its mother's womb, to insure a healthy and vigorous constitution; that every tendency toward abnormality will be prefigured in symptoms, usually subjective, in the mother, and that the physician, if watchful enough, can, will, and ought to discover these and rectify them by the forces which lie latent

in his medicine case. But he cannot do this unless he has a deep insight into general pathology, and can interpret the warnings nature always gives, but gives often in an evanescent, subtle way. He must also possess a broad knowledge of the materia medica, and be able to apply that knowledge deftly.

Whatever proportional credit may appertain to the prenatal or to the postpartum care I give my babies, I will say for them that they are very good babies indeed. They rarely have the colic, they sleep with such conspicuous pertinacity as to alarm their guardians, and they grow up to be healthy little men and women. In seventeen years I have never seen—I am speaking now of my own immediate obstetrical cases—but one baby die during its first month (October, 1883), but one in the second month (October, 1887, of septic poisoning from its feeding bottle; this case I reported in the *American Homœopathist* in January, 1888), and none in the third month. Only one child has had infantile pneumonia (September, 1886, recovered, and is now a robust boy of five and a half years); but one has had ophthalmia neonatorum (March, 1888, recovered, eyesight normal, but died at one year of age from whooping cough). Out of several syphilitic mothers treated during pregnancy, I have had only one child die, and that in its tenth month at the evolution of the first teeth. I have had no case of sprue for four years; no cases of umbilical disease (septic infection, omphalitis, omphalorrhagia) at any time; and but three cases of umbilical rupture; these were all cured. No malformations, not even slight ones such as birthmarks, cephalo-hæmatoma, etc., have occurred in children born of women who have been treated homœopathically during pregnancy. The above statistics apply only to my own 651 cases; I have, of course, seen many varieties of all the above conditions in consultation, in midwife, in spontaneous delivery, and "old-school" cases. Where they have occurred in my practice, as above, it was because my rules, which are always extremely precise and explicit, were knowingly violated by the nurse or mother.

I hope no one to whom these words may come will think for one moment that I plume myself on these successes, or that I mention them for any purpose but to show what homœopathy, with a modicum of common sense, can do. What I have done anybody could do. It does not require any particular ability, except the ability to grasp details, and a conscientious determination to let no woman suffer the pangs of parturition and then lose her child through the neglect or ignorance of the doctor.

It might seem desirable to make somewhat more clear the lines of

procedure adopted during these first hours of life to prevent the occurrence of those accidents to the new-born which are so prejudicial to its welfare. I have already indicated both here and elsewhere* how much faith I have in prenatal medication. As a matter of practical experience I feel that I have now the right to the assured belief that the fœtus can be acted upon through the mother's system; and that it only requires knowledge, patience, and intuition on the part of the doctor, and confidence, ability to interpret subjective feelings into spoken language, and frankness on the part of the patient to insure the obliteration of all faults of construction. Alfred Russel Wallace, in an article entitled "Human Progress: Past and Future," in the January (1892) *Arena*, adopting the theories of Galton and of Weismann, which are included in the term "the continuity of the germ plasm," sets forth with charming lucidity the means by which continued advancement in moral and spiritual development may be secured for the race. But these depend upon, and are in fact indissolubly connected with, physical health and perfection. While there are seeming exceptions to the rule, and sharpness of mind and elevation of soul are occasionally associated with deformity of body, we know that these are so rare that they but accentuate the force of the old saying in regard to healthy minds in healthy bodies. Dr. Wallace shows how these may be, nay, will be secured. Society has always, in one way or another, interfered with those beneficent processes of selection which have tended, and do tend, to eliminate the gross, the vicious, the unhealthy, and has thus retarded the general advance. But society is not to be reformed except through the unit of which it is composed. The methods of this reformation are already known.

In other words, I believe here and now, in this year of Grace, A. D., 1892, we can have children born *mens sana in corpore sano* if we use the power placed in our hands by Hahnemann and the brains placed in our heads by God. To be sure, this requires co-operation between parents and physician of the most intimate kind. It means a capacity for self-sacrifice, for altruistic living, on the part of all three—father, mother, doctor—which, to say the least, is unusual. But there are, doubtless, very many women and not a few men who, if they could realize their opportunity, would gladly embrace it. It is for you, brother practitioners of medicine, to realize *your* opportunity, to awake to the knowledge that the secret of human progress is your problem, and must be solved by you. The medical profession has replaced the

* "Commonplace Midwifery," p. 13, and, "On the Relation of Therapeutics to Midwifery," p. 9.

ancient priesthood. Unfortunately, like it, we are too often false to our opportunity and negligent of the dignity of our calling. It is only the man who himself leads a clean life that can hope to aspire to a work so glorious, so beneficent, so wide-reaching. The dram-drinking, tobacco-chewing, self-indulging doctor is "not in it" at all; and unfortunately too many of us are very human. The opportunity exists nevertheless, gentlemen; shirk it, or rise to it.

It is, then, on prenatal medication that I mainly rely to prevent disorders in the new-born, hampered in the practical application of the purpose by the gross prejudices and the crass ignorance of the community at large. During the progress of labor I discard all so-called antiseptic procedure, and depend upon lard. The hog may be a very objectionable article of diet, but if he existed for no other purpose than to furnish lard for obstetrical work he would not have lived, nor died, in vain. Just how many grains of lard it takes to kill a microbe I do not know. It is possible that the microbe laughs and grows fat on it; if so, then so much the better for the microbe, and none the worse for our baby. For it is to the unstinted use of lard during the whole progress of labor that I ascribe much of the gratifying success which I have had in obstetrical work. But then I am very particular about my lard. "Store" lard is my abomination; it is full of water and all manner of filthiness. It may do to fry doughnuts in, but it will not answer for obstetrical work. In arranging the preliminaries of a labor case I always request that four or five pounds of leaf lard be purchased, and tried out at home. Then we have an article that can be relied upon, and which never fails to justify expectation. Liberally used in the vagina, within the cervix, and upon the child's advancing head, it not only acts as a lubricant, but it greatly increases the elasticity of the maternal parts, and neutralizes all septic germs. I don't like to deal with dirty people. I admit to a certain fastidiousness. But as far as danger of inoculation is concerned, give me plenty of lard, and I'll run the risk; it is minimum. It is to the credit of lard that I have had so few "interesting" cases. The babe slips easily into the world, without rending its mother's tissues, and with no likelihood of septic pneumonia, ophthalmia neonatorum, icterus, nor omphalitis. In fact, as a result, the whole process seems so uncomplicated and obvious that, in the present state of communal knowledge, the doctor gets very little credit indeed. The family say, "What an easy time she had." And as for the baby, why, "It's all right." And the usual fee is looked upon as an almost needless expense; a midwife, at ten dollars, would have done quite as well! Now, if we had only had a bad laceration to

be neatly silver-wired, or a violent ophthalmia, or a pneumonia, and the patients had finally recovered, the chorus would have been, "What a clever doctor we have got!" But do not blame the laity for this lack of appreciation. The medical profession has taught the public to accept bad work for good through centuries of blundering. Can we expect them to know really good work, which consists in *preventing* trouble rather than in curing it?

I have mentioned the absence of sprue in all my new-born during recent years, probably 150 consecutive cases. This, if I may judge from what I hear and read, is a somewhat unusual experience, and at variance with commonly accepted belief. It, therefore, may seem to demand explanation. I may say here that experiences differ so completely that even when two men endeavor to carry out the same regimen with equal conscientiousness the results may be antipodal. Of course the differences in results are explainable when the minutiæ of the operation are made known. Nature works according to rule, and always arrives at the same resultant when the forces are precisely alike. In no manner is this better illustrated than in the infant's mouth during the first hours of life. Now this very question of the desirability of cleansing the mouth of the newborn recently agitated the obstetric mind of Berlin.* As is well known, oval, yellowish-white patches are frequently found in newborn children immediately behind the alveolar arch of the upper jaw, just where the oral mucous membrane covers the hamular process of the pterygoid. It has been generally taught that these patches arise mechanically from the friction exerted during the act of suckling by the tongue on the mucous membrane, which is quite thin just over the hamular process. Dr. Baumm, however, states † that he found in forty consecutive cases in which the nurse wiped out the infant's mouth after feeding, this particular form of aphthæ showed itself in thirty, while such aphthæ were not once found in fifty other cases where the nurse was forbidden to wipe or rub the mouth at any time before or after feeding. From this Baumm draws the lesson that the mouth of the infant should not be cleansed, and that the usual practice, intended as a preventive of aphthæ is, on the contrary, a measure predisposing to these conditions.

From all this I most earnestly dissent. Bednar's aphthæ, as this form of buccal soreness is called, are occasioned by the drying of extraneous particles upon the surface of the mucous membrane, and

---

* *Homœopathic Journal of Obstetrics, Gynecology, and Pedology*, January, 1892, Editor's Table, p. 87.

† *Berlin. klinic. Wochenschr.*, August 24, 1891.

the consequent irritation; this will be most evident in those parts of the mouth where the mucous membrane is the thinnest. Absolute cleanliness will prevent its occurrence. A child's mouth may be wiped out by the nurse and left dirtier than before; and the irritation caused by rubbing roughly over the tender mucous surface may set up serious mischief—something much more serious than Bednar's aphthæ. After each nursing the infant's mouth should be gently wiped out with a soft handkerchief dipped in pure cold water, using plenty of water. After being so used, the handkerchief should be thoroughly washed in boiling hot water and hung up to dry, but not in the sick room. With this precaution my experience leads me to believe aphthæ will never occur.

The value of cold water to the newborn, as a beverage, has been preached with some persistency in recent years, but its real worth is not understood by many in the profession. Simple cold water will allay irritation, induce sleep, and prevent wear on the nervous system during the first hours of life better than anything else. Of course, if there is a pathological condition present, this must be met by the appropriate remedy. But it will sometimes happen that the newborn will be wakeful simply from the effects upon it of extraneous forces, light, cold, noise. These, if disturbing to the child, must be modified, and then a spoonful or two of pure cold water will remove their effects and act like an anodyne. Many times I have seen a child, who had been wakeful and fretful for hours, drop off instantly into a quiet, peaceful sleep on being given a few spoonfuls of water. To a newborn it must, of course, be fed slowly, a few drops at a time. The importance of that first long sleep immediately after birth cannot, it seems to me, be overestimated. To secure this, however, I would be unwilling to give, and never find it necessary to give, any of the ordinary anodynes, anise-seed tea, catnip tea, etc. Later, after the first weeks, I yield so far as to allow a little weak anise-seed tea, when the child is fretful and the mother seems bent on using it. It is sometimes desirable to let a woman have her own way, especially when you know she will take it as soon as your back is turned. But while she is still in bed, unless the nurse is one of those creatures who thinks she has forgotten more than I ever knew, I can generally manage things to please myself; even here I find things don't go quite to my taste sometimes. I remember some dozen or so years ago, before I had learned the deviousness and mental obliquity of the Sairey Gamps and Mrs. Harrises, leaving a case, after all was over, somewhat hurriedly, as I was called elsewhere, and coming back some three or four hours

after to find that the baby had had five different kinds of medicine poured down its throat. Not that there was anything the matter with it particularly, but on the general principle that "castor oil and sich" was good for infants!

I have thus indicated what I consider the sources of success in midwifery practice, if we would have the best results in the fruit of the womb. It will be perceived that it may be all summed up in the brief phrase—attention to details. The treatment, to be really scientific, must fit the case, and this not in any perfunctory way, but in the sense of being made for it, of being conjoined with it, so that case and treatment form a unit without interstice, and this, again, not at some one stage of the case, but from its inception to its close, from the moment of conception to the conclusion of the lying-in.

REPORT

OF THE

BUREAU OF SURGERY.

"A Radical Cure for Retrodisplacements of the Uterus," F. F. LEHMAN.
"How far has the performance of Hysterectomy proven itself to be a justifiable procedure?" - - G. C. JEFFERY.
"Nephrorrhaphy, with a report of two operations for Movable Kidney," - - - - SIDNEY F. WILCOX.
"Cæsarian Section," - - - - H. WILLIS.
"Anal Sphincter Stretching," - - - - W. M. L. FISKE.

A RADICAL CURE FOR RETRODISPLACEMENTS OF THE UTERUS.

F. F. LEHMAN, M. D.,

House Surgeon to the Rochester Homœopathic Hospital. Service of Dr. J. M. Lee.

The purpose of this report is to bring before the profession a method of procedure which has proved to be a radical cure for retrodisplacements of the uterus. This result may be obtained by either Wylie's, or Alexander's operation. They are both valuable, but for different conditions; and when one is called for the other is contra-indicated. Alexander's operation is only useful when there are no firm adhesions or any disease of the appendages sufficiently grave to make it necessary to open the abdominal cavity. However, the majority of cases are not of this class. As a rule when there are serious symptoms associated with retrodisplacements there is some disease of the ovaries or tubes, or both, which will not yield to other than surgical treatment. It is in this class of cases that Dr. Wylie's operation is indicated. I am aware that Skene and others would first liberate the uterus, then follow Tait's operation with that of Alexander; but this subjects the patient to unnecessary risk and mutilation. We cannot ignore the great importance of restoring retrodisplacements at the time diseased appendages are removed. It makes but little difference how badly

diseased the tubes and ovaries may be, the immediate results of Tait's operation will not be entirely satisfactory unless all backward displacements are corrected. It is true that if one will have the patience to wait for atrophic changes to take place the patient will finally regain her health ; but this takes from six to eighteen months, and it is very difficult to make them understand that in time they will be cured.

During the last year it has been Dr. Lee's practice to correct by Wylie's method every retrodisplacement of the uterus at the time diseased tubes and ovaries have been removed. There has not been a single instance in which the relief was not prompt and apparently permanent. As Wylie's method is comparatively new to the profession I take this opportunity to report its results in several cases that have been under treatment in this hospital.

First, a few words on the technique of the operation:

The patient is as carefully prepared as for any other form of abdominal section. The bowels are evacuated by a purgative dose of oleum ricini. The genitalia and abdomen are shaved and thoroughly scrubbed. On the morning of the operation a hot douche is given, and throughout the strictest asepsis is observed. No sponges are used save a known number made of absorbent cotton wrapped in gauze. The wound is kept dry by dossils of cotton wrung from hot water, and these, once soiled are thrown away. All adhesions are broken up or ligated and divided. The appendages, if diseased, are removed, and the fundus uteri restored to its normal position. Each round ligament is brought up by the fingers, then grasped in the center of its length with a pair of forceps, folded upon itself, and elevated out of the wound as much as possible. Two or three silk ligatures, according to the laxity of the ligament, are passed, first through the center of one side of the fold, then through the center of the other side, and tied. This cuts off the circulation from but one half of each side of the fold, while between the ligatures it is not materially interfered with. In this way the round ligaments are sometimes shortened two or three inches. The silk becomes encysted and gives no trouble by its presence, while at the same time it strengthens the adhesions which take place between contiguous surfaces of the folded ligaments.

The following cases taken from the hospital records are given in illustration of the above entitled method of procedure.

CASE I.—Mrs. D., aet. 39, housewife; has had seven children. There is a very decided history of tuberculosis in both branches of the family. In early life the patient was thought to be going into consumption, but after marriage, at the age of seventeen, her health

improved until the birth of her first child. Since that time she has never been free from tearing and darting pains in the back, base of brain, and legs. About four years ago the right ovary was removed. This afforded relief from the pain in the right inguinal region and the right leg, but not from the backache nor headache. One year after the abdominal section her youngest child was born, and since then she has grown steadily worse. There is a constant fetid vaginal discharge.

Examination, October 1, 1891, revealed a ventral hernia, which is a sequel of the abdominal section. The uterus was enlarged, prolapsed, and retroflexed.

Operation October 2nd. The hernial sac was dissected out, the left tube and ovary removed, and the uterus brought up and forward and held in place by shortening the round ligaments.

The patient made a good recovery unattended by complications. While in the hospital she did not experience any of the pains from which she suffered on admittance. The headache, backache, pelvic tenderness, and pain in the right side and leg have all ceased. She left the institution Nov. 31st feeling remarkably comfortable.

CASE II.—Mrs. K., aet. 57, housewife, has borne one child. At the age of 21 the patient suffered from some acute disease the nature of which is not definitely known. After her recovery she did not menstruate for six months, and when the flow was re-established it was attended by severe pain which was relieved by hot applications. During the intervals she suffered from constant pain in the back, heat and tenderness in the pelvis and abdomen, headache and insomnia; she was also very nervous, weak and hypochondriacal. September 30th an examination showed the uterus retroflexed, and at the point of flexion the tissues were atrophied to the thickness of card board.

On October 1st the diseased ovaries were removed and the uterus held in place by shortening the round ligaments as above described. The result was all that could be desired. The temperature chart showed no deviation from the normal, save on the fourth and fifth days when 100.5° was registered. She was discharged October, 29th. A letter of inquiry sent the latter part of November was answered thus: "I am now free from all my former pains, and am improving every day. I am looking foward with great pleasure to years of health and comfort."

CASE III.—Mrs. C., housewife, has had two children. Pain in left groin whenever fatigued, backache, though not severe. Her troublesome symptoms were mostly confined to the head. She constantly experienced a "gone and dazed sensation." She was nervous, irrit-

able and down-spirited, so much so that her naturally bright and vivacious disposition was said to have changed to an alarming degree within the past year. An examination under chloroform revealed a tumor of the left ovary and a retroflexion of the uterus. The tumor proved to be a dermoid cyst and was removed. The uterus was then brought foward and held in place by shortening the round ligaments according to Wylie's method.

No shock followed the operation, and the patient rapidly recovered her former buoyancy of spirit. She was also free from a feeling of weight about the hips, and the whole body was described as "much lighter." Her head became clearer, and she left the hospital December 1st, well.

CASE IV.—Miss M., aet. 40. Occupation, none. In early womanhood she became a mother *ex legibus*. At this time she probably contracted syphilis which played sad havoc with her eyes and set up a choroiditis from which she nearly lost her sight. On admission to the hospital her chief complaints were great pain in the back and sides with obstinate constipation. Her nervous condition was pitiable. She was wholly unable to carry on ordinary conversation. October 26th, the abdomen was opened, the diseased ovarian tubes removed and Wylie's operation performed to correct the retroflexion.

A few days ago I received a letter from her in which she stated that she was free from all the old aches and pains. Her general health is much improved, and both the patient and her friends feel very exultant over the success of the treatment.

CASE V.—Mrs. M., aet. 52, dressmaker, has had two children and passed the menopause at 50. November 7th, was admitted to the hospital. She complained of constant pain in the back and sides, which was often aggravated by paroxysms of more severe pain. After eating she felt as if there was no room for "food or breath." Examination showed a retroflexion which was corrected by Wylie's method of operating. Her recovery was tedious and prolonged, owing to the development of two deep stitch abscesses in the very thick abdominal walls. She was however relieved of all her former pains.

HOW FAR HAS THE PERFORMANCE OF HYSTERECTOMY PROVEN ITSELF TO BE A JUSTIFIABLE PROCEDURE?

GEO. CLINTON JEFFERY, M. D.,
BROOKLYN.

Among all men, during the period of all civilizations, they have universally proven themselves to be the blind devotees, and followers of the prevailing customs of their times, whether such habits, or methods have lain within the domain of prose, poetry or physic. It may not, therefore, be unnatural or peculiar that we of this time and age still continue to follow in the same way the leadership of the many investigators and originators of new truths and ideas as they apply themselves to the many special developments that are helping to raise the standard of improvement and method in the practice of our own chosen profession. Men have everywhere, however, too often proven themselves to be simple conformists, and have followed without personal reflection too often the leadership of him who may have suggested methods which, as applied to our profession, have in many instances proven a misfortune rather than a boon to him who has so eagerly cultivated, and faithfully applied in his practice the ideas originally proposed, and so unadvisedly suggested. In this respect we show a certain resemblance to one reputed paternity and origin, in the ape who proverbially becomes a ready imitator until error in judgment is too soon proven by some unhappy venture, which exposes him to the danger of accepting any statement or example upon the simple endorsement of faith alone. Surgery and its practice has, as has been too often proven, to require from me the efforts of a substantiating voice, one of the greatest salvators to our suffering humanity. The irritating substance lodged within the bone or muscle by the dextrous hand of the operator, soon gives away to the possibility of early healing, and rapid restoration. The pent up contents of a pus cavity is at once freed from its environments, resulting in the immediate relief of pain, the dangers of pyæmia, and the rapid restoration to wonted health. The cataractous eye exchanges its blindness for welcome sight while the rapidly failing vision incident to glaucoma, finds its only remedy in the surgeon's knife, while deformity of flesh and bone, wherever found within the human frame, pays respectful homage to the same potent origin. For all, then, that surgery and its practice has offered,

and given as a boon to suffering humanity let us be sincerely thankful. That it so often combines absolute safety with its multiform benefits, while at the same time regretful that its best results are often not obtainable without the dangers of fatality or deformity, if even satisfactory results are attained at all. The range of surgical practice, it seems to me, holds to itself sufficient for all of the proper demand that should be made upon it within the field of conservative and life giving (instead of life taking) boundaries. To remove the necrosed bone, to extirpate the gangrenous extremity, to separate the carcinomatous tissues from those that soon must become fatally contaminated if allowed to remain in contiguity, to replace and restore for permanent healing and future usefulness the ragged segments of the fractured bone, together with exacting labors of a similar class, must give to the surgeon sufficient variety of labor to gratify, it would seem to me, the most outstretching ambition in the domains of the special variety of practice; unless perchance the interference of the surgeon's knife was *conscientiously* applied only with the meritorious hope of saving life or retarding the progress of declining health.

May I ask it in the most truthful sincerity is this alone the motive that guides the practicing surgeon of to-day, when an operation is made possible, involving the life and future of his patient's welfare. The contrary is as I have observed it. The *first* consideration lying in the size of the prospective fee that is exacted. The *second* in the patient's or her executor's ability to pay it. The thought of saving life is too often sacrified, when the hope of being handsomely rewarded for an hour's work is made in any way possible, while perfect success is *invariably promised* whether the patient survives the ordeal or dies under it. In any event the operation is bound to be thoroughly successful in its results, if not to the patient entirely so to the surgeon, provided he receives at the proper time, a liquidation of the existing account previously contracted between them. There seems to me again to be a disposition more especially upon the part of surgical gynæcologists to rival each other as record breakers, rather than applies to the general surgeon, who in his field of practice deals more with the physical deficiencies of men. While in the former, the operator frequently succeeds in accomplishing the desired ends if a persuasive manner upon his part with a degree of sentimentality are combined in proper proportion in the mixture. A woman lives more in a sphere of anticipation than a man. Men deal more with the present, and meet its demands and requirements day by day as they present themselves to him, besides women are creatures always possessing an ideal, that

is to live in her future and to deal with effectiveness with her sex, is to paint a picture to her mind, of present pain, soon uniting itself to greater misery, all to end in untimely death (unless speedy means of rescue are intervened), is sufficient of itself to win the early consent of our patient, who readily submits herself to any operation we may suggest, provided in the first instance that we have fully gained her confidence in our ability to successfully terminate the undertaking, a preliminary indeed very essential in every professional undertaking, whether it lies within the domain either of surgery or simple medicine. If it were otherwise this surgeon or that one could never have claimed the performance of not one, nor a dozen, but hundreds in fact of laparotomies for the removal of the malevolent and culpable ovaries, which as a *strange* and *peculiar coincidence* has been the factor, and promotor of pain and nervous phenomena mostly confined to the women of our own time and generation, for if you will show me one man who would suffer castration for anything short of malignant and *certainly fatal* disease of the testicle, I will show you a thousand women who will quietly and without a protest submit to an early removal of her ovaries simply as the result of a calculating persuasion, who indeed have surrendered their proverbial persistency, before many methods that might have proven themselves entirely or fully as effectual, have ever been attempted or tried at all. I trust that I may be fully understood as not claiming immunity from any of the charges that may apply themselves to many other surgeons, as I have, I fear, much of a similar defence to prepare to be offered in extenuation at a later day, simply because some of my patients have failed to exhibit at the critical time sufficient reserve of vitality to have crowned my efforts with all of the success that I had fondly hoped to attain. I may now, I believe, after contemplating such an extended preface ask in this place, the question that gives the title of this paper, namely: "How far has the performance of hysterectomy proven itself to be a justifiable procedure."

The answer which I would interpose previous to the argument is, that only so far as the *present* condition of the patient was such that active interference was demanded to save life, and not because the patient suffers embarrassment at the frequent congratulations of her curious acquaintance, who mistake her rotundity of form to mean progressive pregnancy, not because she on her part *believes* herself to be the victim of a tumor whose progress means the shortening of her life, not because she is the unhappy subject of mental disturbance that heartlessly allow her to be possessed of imaginary vagaries of the mind

that will never be realized, but simply and for the most potent of all affirmative reasons as the intelligent surgeon well knows that such tumors are *absolutely benign in their nature*, and *are never* in themselves dangerous to life. His first duty, therefore, is so apparent as to become an axiom, which should teach him, if possible, to relieve the morbid fears of his unhappy patient, and readily suggest to her other methods to be invariably tried, that have been proven *not to be fatal to life*, and which have repeatedly been demonstrated to have been partially if not wholly successful in many proven cases. Electricity in the different forms of myomata has demonstrated itself many times to have been not only a benefit but productive of a cure in frequent cases. Drugs that have been proven to possess the power of producing, and maintaining contractions upon large growths within the cavity of the uterus must always—if long persisted in—prove a benefit owing to the pressure produced by them. While it is an established fact well known to us all that small growths have frequently been expelled from the uterus when such methods have been methodically and assiduously employed. Ligation of the uterine nutrient circulation defines as has well been proven the progressive growths of these tumors, besides limiting the excess of hæmorrhage that frequently attends them, and to me seems to meet the indications of a method of treatment (while attended with a comparatively slight degree of danger to the patient), that should always be employed, provided the tumor is not too large to present contact with the vessels through a small abdonimal incision. Enucleation and excision has proven itself effectual in many instances and deserve sincere consideration as a method to be preferred to the more hazardous one of hysterectomy provided the indications of the case are capable of being effectually met by such a plan, but if hysterectomy is to be employed I believe that the following indications should determine its employment and then only after safe means have been duly considered and employed.

Firstly. Frequently recurring and exhausting hæmorrhages that are menacing the comfort of the patient and endangering the continuance of her life.

Secondly. Where the tumor has grown to such dimensions as to interfere with the proper performance of the excretory functions of the body.

If after the performance of hysterectomy the operation was followed always by the very favorable results liable to be promised in event of recovery, it might in a large measure compensate the patient for some of the risks of the undertaking; but when we recall the

number of cases of lasting enervation, the painful and often unmanagable protrusion of the gut in ventral hernia, the multiform phases of neuralgia localizing themselves afterwards in the pelvis, together with persistent headache, it might be well to cause our asking the questions of ourselves if these are not a few negative arguments against the indiscriminate performance of this operation. In my own experience where I have opened the abdominal cavity, on several occasions, I am reminded too often for my comfort by one or two patients with whom I am unhappily familiar, that all I had so fondly promised had not been fulfilled owing to their continued sufferings from existing ventral hernia.

From Dr. Stephen Smith's Surgery, I quote the following: "Gastrotomy undertaken for the removal of sub-peritoneal tumors of the uterus is justifiable only when the general decadence of the patient's strength makes it *certain* that a fatal issue must ensue."

Dr. T. Galliard Thomas, in his Diseases of Women, speaking of the indications for the performance of hysterectomy does so as follows: "Gastrotomy should be performed only when life is in jeopardy."

From Holmes Surgery, page 998, I take the following: "The sub-peritoneal fibroids are less amenable to surgical treatment, and it is only when such tumors *positively* endanger life that surgical interference is justifiable."

Dr. Thomas Keith, who up to this time is probably by far the most successful operator, in speaking of this subject says: I often ask myself the question, does a mortality of eight per cent. justify an operation for a disease that as a rule has only *limited* active life, that torments simply and that only for a time, though of itself rarely kills. The mortality of an ordinary uterine fibroid if left alone is *nothing* approaching a death rate of eight per cent. I doubt even if the mortality of the extreme cases exceeds this. And after all the great difficulty is not in doing even the worst of these operations, but in knowing what are the cases in which *it is right* to advise those who trust themselves to us, to run the risk of a dangerous operation with all of its attendant miseries, could we get the mortality down to five per cent. in bad cases, and *these only* are and be fit subjects, then one might advise interference with a more easy mind." Further in another paragraph Dr. Keith continues, "All of my operations were done on account of repeated hæmorrhages and ruined health." These voluntary utterances of eminent authorities should speak volumes at least, as regards the conscientious selection of those cases where the operation is entirely warrantable and, the *absolute refusal* of those cases where

the patient has retained a large degree of good health, is free from continuous pain and exausting hæmorrhage, and is in such a favorable condition of health, as to avail herself of other methods less liable to fatality and probable death. Besides, there is another consideration to be offered upon the negative side of this question, which is the universal acknowledgement as to the benignity of the fibromata of the uterus. They are entirely free from malignity, they do not reach out and fatally involve surrounding healthy structures nor in any way become the foci of septic infection to the systemic circulation, (unless they become dangerous when the curative methods of absorption are being employed). They simply are born and begin their growth in their infancy adding thereto strength and development to the period of the middle life, when after the menopause they take on the atrophic conditions of old age. There is usually no indication in their treatment that demands haste, but on the contrary the most deliberate and calculating introspection, and, the illustrations are many where they defy interference, and spontaneously cure themselves, or are expelled if sufficiently small into the vagina, where they become an easy prey to the surgeon's knife and are promptly extirpated with almost absolute freedom from danger to the fortunate patient. Gusserow in speaking of the character of these growths thus expresses himself. "The prognosis in cases of uterine fibromata if received from purely anatomical standpoint might be unhesitatingly pronounced good. These local and homologous tumors are *par excellence* of a benign and simple character."

I find on research statistics accumulated on the subject of the results of hysterectomies performed by various surgeons previous to the year 1878 as follows: Péau collected 44 operations with 30 cures. Mortality 68.2 per cent. Marion Simms found among 11 extirpations done in England; 2 cures. Mortality 82 per cent. Among 11 operations done in America; 4 cures. Mortality 64 per cent. Among 18 operations done in France; 11 cures. Mortality of 39 per cent. Caternauet found among twenty gastrotomies in which only the tumors were removed, twelve deaths and eight recoveries. Mortality 60 per cent. Routh collected 48 laparotomies performed on account of uterine tumors, 15 of these were not completed (with 7 deaths) and 33 were completed (with 23 deaths). Schroeder found among 108 laparotomies performed for uterine fibroid, 16 cures and 78 deaths, namely: cures in 14.7 per cent. and deaths in 85.3 per cent. Of these 108 laparotomies, 73 were combined with extirpation of the uterus, among these cases were 55 deaths and 18 recoveries. The

tumor alone was removed 35 times, death occurring in 23, and recovery in 12 cases. I have also collected the record of 533 cases the operations having been performed by nineteen different operators, between the years 1883 to 1885 resulting in 338 recoveries and 185 deaths. It must be conceded that the improvement in the methods employed, and the scrupulous antiseptic care generally availed of by our most recent operators, has, I believe, improved the percentage of mortality being much below the statistics previously offered, but yet when we recall the fatal history of the past and at the same time consider the many meritorious methods of the present we may well pause, and ask ourselves just how far the performance of hysterectomy has proven itself to be a justifiable procedure.

But is there no middle ground of compromise which may be suggested, which will comprise both adequacy of favorable results combined with comparative safety to our patient. There certainly should be and I believe that there is in the employment of electrolysis, enucleation, and the removal of the ovaries and fallopian tubes, where such a plan is made possible by the size and location of the growth setting aside all other methods as useless and inoperative. In the performance of enucleation there are many dangers, both of a traumatic and septic nature but far less than are offered where hysterectomy is performed, and when successful in its results generally leaves the patient in a far better condition for future health and comfort, than when the uterus and tumor have both been removed. Small growths are often easily managed where the use of the ecraseur is made possible, and in the sub-mucous form of fibromata is more easily and effectually employed than in the other varieties. Regarding the employment of electrolysis it has many conscientious and sterling advocates who base their favorable impressions alone upon the benefits that have been obtained in their own hands, and by others of their own knowledge. It may be claimed for this method that it will always reduce the dimensions of the growth, but it becomes a matter of reasonable doubt if a uterine fibroma was ever known to entirely disappear under its use however assiduously employed. For special information upon this subject I have taken occasion to pen two letters, one to Professor Alexander Skene another to Professor Charles Jewett of Brooklyn, both gentlemen known to have had large experience in the employment of electrolysis in the the treatment of these growths, and I give you verbatim their replies to me as they have written them. In my letter to Professor Jewett I glean this

question. "Has electricity ever cured a case of uterine fibroma in your hands, and, what has been your experience in its use. This is Dr. Jewett's letter.

"My Dear Doctor.

I have your note of this morning. In reply I beg to say that after a considerable experience in the treatment of uterine fibroids with electricity I have seen no reason to believe they can be destroyed by galvanism without puncture; an œdematous fibroid may be condensed by the current and may remain smaller for a time, but absorption I believe is not possible. The galvanic current without puncture is valuable for the *arrest* and *prevention* of hæmorrhage and, to some extent for the relief of pain and pelvic tenesmus that frequently obtain in this class of cases but no further. The statistics of the L. I. C. H. I could not give you, but have no doubt you could get them from Dr. Skene. Electricity so far as I know has not been used for that purpose in the hospital. Very truly yours,

CHARLES JEWETT."

Taking his suggestion to communicate with Dr. Skene, I penned the doctor the following questions:

First. "The percentage of mortality at the Long Island College Hospital after abdominal hysterectomy and whether it had been greater by the supra- or sub-peritoneal methods."

Second "Has electrolysis *ever cured* a case of uterine fibromata in your hands; and has it any value other than a hemostatic in your judgment." To which I received the following reply.

"Dear Doctor Jeffery.

The mortality in my hospital practiced after abdominal hysterectomy has been 20 per cent. supra-peritoneal methods in all cases. I have *completely cured* three cases of uterine fibromata with electrolysis, and given perfect relief to ten and partial relief to quite a number. Yours truly,

ALEX. J. C. SKENE."

The experience of these gentlemen will I doubt not coincide with that of many others, who have employed similar methods in the treatment of these cases. What shall be said of the removal of the ovaries and fallopian tubes as a remedial measure to be employed in suspending and terminating the progress, and development of these growths. It is no longer an experiment that such treatment has proven itself efficacious and sufficiently free from fatality to warrant it being placed among the chosen means to be availed of in these cases. There are however some fibromata where it cannot be employed owing to the size and

dimensions of the growth, or from adhesion of the tubes to the uterine parietes, but yet there are many cases where the operation may be made available before assuming to advise the more formidable procedure of total extirpation of the uterus, Skene says, in his work, page 364. "Removal of the ovaries for the relief of small fibromata which cause exhausting hæmorrhage has given very satisfactory results. This plan of treatment was suggested by the fact that these neoplasms disappear as a rule after the menopause. Reasoning from this it was presumed that by removing the ovaries, and thereby inducing the cessation of the menstrual function prematurely the same effect upon fibromata would be obtained, practically it was found to be so hence in properly selected cases the removal of the ovaries is the best treatment." Lawson Tait in his work page 209, in speaking of fifty cases where this method had been employed, says. "In seventeen cases I know that the tumors have entirely disappeared, and in fourteen they have been so materially diminished in size as to remain perfectly harmless. My more recent experience has been still more favorable, for my recoveries are now more prompt, and the arrest of hæmorrhage more immediate, and I feel perfectly justified in saying that in this operation we have one of the most valuable additions to surgery which has been made in recent years." I in my own experience, have removed the ovaries and fallopian tubes, fourteen times with but one death to mar the perfectness of my modest record. Four of these cases were operated upon for uterine fibromata, three of moderate size and one so large as to make the ligature extremely difficult, through an extensive abdominal incision. In all of these cases I have testimony to the fact that the menstrual hæmorrhage was markedly diminished or entirely ceased while in all there has been a marked attenuation in the size of the original growth. There might upon a subject comprising the magnitude of details of one of this kind not only pages but books be written and I feel that the limits of your patience, bids me draw my subject to a close, but with a word upon the possible advantage of hysterectomy, I shall have done. Upon reading the comparative records that have been published regarding the statistical results of the mortality after this operation, one cannot but pause and note the improvement that has marked the favorable results within a very few years, and, as we are living in a world of rapid development in the perfection of all methods and practices for the benefit of mankind, it certainly becomes a serious question upon the affirmative side of this discussion, as to whether a cessation of progress towards greater perfection of result in the practice of surgery should be deliberately discouraged and declined. If there was no middle

ground upon which to stand, an affirmative reply it seems to me would be entirely and positively warrantable, but when we have had it proven by the test of our own experience, combined with our observation in the practice of others, that the growth of uterine fibromata have been successfully discouraged by other methods than that of hysterectomy, (it very naturally causes us to raise the question of advisability) within our own minds. Men and methods have and will probably after our day continue as at present to differ in thought, and ideas as to the propriety of different plans of action, but all that the writer has expressed upon this subject has been done with the hope of encouraging the desire upon the part of the surgical fraternity to take some new views of an old subject. How much better off would our civilization be and how much less rapidly the records of mortality would accumulate if precision of method and unanimity of action could be given us by some unseen hand in the vital treatment of this and other forms of formidable disease. We have not yet the goal of perfection in our medical and surgical ambitions, and must yet at least for a little while humble ourselves to the truthful adage of Sir Isaac Newton who compares us to little children playing with shells upon the shore while the great ocean of truth lies undiscovered before us.

DISCUSSION.

S. F. WILCOX: I want to enter a protest against accepting too literally the strictures, or the implied strictures, in Dr. Jeffery's paper. I do not believe for one moment that the majority or even a small minority of operators do laparotomy work solely for the money there is in it. I think that surgeons are just as conscientious as other specialists or the general practitioner; we offer the patient the only chance for her life. We do not do this simply for the fee. There may be such men, but I do not know any of them. I have never seen a case of ventral hernia following laparotomy.

DR. JEFFERY: If I had had time to complete the reading of my paper, and my authorities, I think the doctor would not hold me guilty of charging all surgeons with undue anxiety to make laparotomies. I did not say all surgeons nor the majority of them, I said "many surgeons;" and notwithstanding what the doctor has just said I still believe that "many surgeons" do make these operations when there is practically

no chance for recovery. My paper gives the authorities for what I barely referred to in the parts which I was able to read in the time allotted.

NEPHRORRHAPHY, WITH A REPORT OF TWO OPERATIONS FOR MOVABLE KIDNEY.

SIDNEY F. WILCOX, M. D.,
NEW YORK.

The origin of the operation for nephrorrhaphy is not definitely known. While generally credited to Hahn, of Germany, it is stated by some authors that it was first performed by an unknown surgeon in Mobile, Ala., previous to the year 1870. The operation is made for the purpose of fixing a movable kidney as nearly as possible in its proper position, in order that the patient may be relieved of the pain and danger incident to its movement.

By movable kidney we understand that condition of the organ in which, after becoming detached from its normal fastenings, it has a tendency to slip about from place to place, its excursion being limited by the length of its pedicle. The kidney may move either within or without its fatty capsule. Sometimes the movement is limited to a slight displacement downward and forward, and in other cases the distance from the normal site may be so great that it may be mistaken for a tumor of pelvic origin. There are two varieties of this condition, *i. e.*, movable kidney proper, and floating kidney. The first is where the organ is outside the peritoneum and slips about behind it, while the second or floating kidney is more or less covered by a reflexion of the peritoneum known as the meso-nephron, and it may thus lie, to a greater or less extent, within the abdominal cavity. Floating kidney is always congenital. An exact diagnosis as to which variety is present cannot be made without an exploratory incision. A movable or a floating kidney may be, and usually is, otherwise a healthy kidney.

Causes.—Anything which has a tendency to greatly relax the abdominal walls or to bring about a sudden loss of peri-renal fat may act as a predisposing cause, while a fall, a sudden strain, or a severe blow over the renal region may act as exciting causes. The right kid-

ney is far more frequently movable than the left. Movable kidney is more prevalent among females than males (proportion 82 to 14), and this greater frequency may be traced to two causes: first, child-bearing, which has a tendency to render the abdominal walls lax while the increase in size of the uterus has a tendency to stretch the attachments of the kidney. A second reason for the greater frequency of its occurrence in females, especially among the laboring classes, is that they wear their clothing suspended from a tight band about the waist. This induces greater pressure from without against the kidney, which may be augmented by the extra pressure of straining when lifting or working hard. Pressure downward of an enlarged or cancerous liver has been known to displace the kidney.

Symptoms.—The symptoms of movable kidney are many and often very severe. They may consist of dragging pains and a sense of weight in the loins; there may be severe attacks of colic with great sensitiveness over the misplaced organ; gastric disturbances, vomiting, fetid breath, palpitation and many hysterical and hypochondriacal symptoms are often present. Sometimes there are symptoms of cystitis and other urinary symptoms, pus in the urine, and intermittent hydronephrosis. These symptoms may be greatly aggravated by walking or riding. The female organs of generation are often disturbed and all the symptoms are aggravated during menstruation. Icterus and hepatitis from circumscribed peritonitis are sometimes occasioned by pressure of the movable kidney on the liver. Death has resulted from the bursting of an abscess of the ureter connected with a movable kidney, and dangerous symptoms such as uræmia sometimes ensue.

Diagnosis.—Concerning the diagnosis of movable kidney, Keen says: "Given a movable tumor in the flank which can be displaced into the iliac fossa or even beyond the median line, which can be pushed back into the position of the kidney, and which has about the size and shape of a kidney, the diagnosis is clear. . . . The size and shape of the tumor is a reasonable guide and sometimes, though not frequently, the hilum can be made out and pulsation of the renal artery felt." "Tumors of the omentum or of the mesentery are most likely to be confounded with it."

Cases are reported where a distended gall-bladder has complicated the diagnosis.

Manual examination may be made by having the patient lie on the back, and when the air is exhausted from the lungs the fingers are pressed deep in so as to get them below the lower edge of the kidney.

Then keeping the hand in place, the patient inhales and thus forces the kidney down into the grasp of the examiner.

The only curative treatment is operative. The kidney may be kept in place in some cases by the use of the bandage and pad. These may palliate the symptoms but of course can have no curative action.

The operations are two, nephrorrhaphy and nephrectomy. The latter, it seems to me, need hardly be considered unless the kidney is a diseased one, which is rarely the case. It is an unnecessarily severe and dangerous operation for the condition under consideration.

Nephrorrhaphy is best performed through an incision running downward and forward between the last rib and the crest of the ilium. It is better if made nearer the rib than the ilium. To mark the position where the kidney should be it is well to make a little nick in the skin one-half inch back from the middle point of a line drawn from the anterior superior spinous process, to the posterior spinous process of the ilium. Sometimes the space between the rib and the iliac crest is very narrow, and in order to widen this space as much as possible, a hard cushion or sand bag should be placed under the opposite loin. It is well to make a sufficiently long incision so that one can have plenty of space to work in. A short incision adds nothing to the good result, while it may greatly embarrass the operator. After cutting through the external muscles, the outer edge of the quadratus lumborum should be felt for. Next, the peri-nephritic fat should be torn through until a firm organ is reached. All this time the kidney should be pressed up towards the wound by an assistant. Of course, care should be taken not to wound the peritoneum. If such an accident should occur the wound should be immediately stitched up with fine catgut sutures.

When a firm organ is found it must be carefully examined to make sure it is not the liver. The color of the liver is brown, while that of the kidney is blue or black. Also the size and shape of the organ presenting being traced out will help determine its identity. The kidney having been recognized, it may be nesessary to find whether a stone is imbedded in its substance or not. This can easily and safely be done by passing a long aseptic pin through and through the kidney substance a number of times, the points of puncture being near together. If a stone is present it is highly improbable that it will escape the point of the pin.

The next step is the fixation of the kidney to the abdominal wall.

Keen, summarizing from a paper by McCosh, says there are four methods used for fixation :

"I. The sutures may be passed through the adipose capsule alone.

"II. They may be passed through the fibrous capsule of the kidney itself.

"III. They may be passed through the parenchyma of the kidney.

"IV. The fibrous capsule may be stripped off the kidney in order to obtain a raw surface of renal tissue, by means of which the adhesions it is believed would be firmer. The sutures are then passed through the parenchyma and the capsule just inside the border of the raw surface."

This last and the most radical method was the one employed in the two cases I am about to relate. The method of introducing and fastening the fixation sutures which was employed in Case II is, I believe, the best, as giving a firmer and steadier approximation of the kidney substance to the abdominal wall, and in order not to lengthen this paper unduly, the further description of the technique of the operation will be given in the recital of the cases.

CASE I.—A single lady, forty-six years of age, by occupation school teacher; patient of Dr. L. A. Opdyke, of Jersey City. The previous history of the case I will give in the patient's words: "The beginning of this kidney trouble I think was in the month of March, 1888. After having stood still at a dressmaker's for about half an hour, I was seized with a sort of spasm and sank to the floor. My face became pallid and cold and I had the appearance of one about to die. The pain was in the abdomen; it was relieved by a dose of Jamaica ginger, and in a quarter of an hour had vanished. When it had passed, I felt as well as usual. About a fortnight later a second attack occurred which lasted about two hours. I have never experienced any pains just like those two attacks before or since. I felt as though I was being cut into with a dull knife. All through the summer of '88 there were severe pains of a neuralgic character in the abdomen, which early in the fall seemed to centre in one spot. Some time in the following winter I was sure I felt something move in the abdomen like a tumor. My physician also found the supposed tumor. In March, 1891, Dr. Dillow, of New York, made two examinations and found the 'lump or tumor.' This was not stationary, for sometimes we could not feel it. The pain in the abdomen always centred over it. The pains through the abdomen became more and more frequent, but this centralization of pain occurred at intervals varying in length, and so severe that relief could be found only by the injection of morphine. In March, 1889, extreme pain in the urethra during urination was felt. A pain as sharp as an electric shock, sent to the ends of the

fingers. This also was spasmodic, occurring at intervals of three or four days. At this time I first felt the difficulty in the region of the right kidney. When I took my usual walk (from thirty to sixty minutes) there was a swelled feeling, or as though there existed something I wanted to take out. At the same time my head troubled me when walking. I often felt that I must fall backwards, and as though I must die. These various symptoms continued, increasing in intensity until March, 1891. At that time I felt my strength to be failing so rapidly that I was sure I could live but a little while without surgical aid. After your examination in March of this year (1891) the pain in the urethra became much more intense and the specimens of urine, when examined with the microscope, indicated serious trouble. One other symptom was also aggravated, or perhaps changed. The strange feeling where the right kidney should have been was for three or four weeks as though I carried a weight of several pounds there. When I walked or stood for several minutes I was completely tired out."

This history has been given at length to show how severe and varied the symptoms may be.

I was called in March, 1891, to see this case in consultation with Dr. Opdyke. The patient was in a painfully nervous and hysterical condition, and suffered extreme pain, especially aggravated by walking or riding, and from the severity of the symptoms I was inclined to think that the movable kidney contained a calculus. The kidney could be easily felt although its shape could not be well defined. It appeared about as large as an adult fist, could be moved nearly to the median line of the abdomen, and was exquisitely sensitive to touch.

The operation was deferred until May 16, 1891, and was performed at the patient's boarding house in Jersey City. The incision was made as before described, but in coming down over the kidney I made an incision about an inch long through the peritoneum. This was found on careful examination to partly cover the kidney, forming a mesonephron, thus bringing this case within the class of "floating kidney." The opening in the peritoneum was immediately stitched up with a continuous suture of fine catgut; and the fibrous capsule of the kidney was then split at a point further back not covered by the peritoneum. The length of the incision through the capsule was about three inches, and the two edges were stripped back, leaving a raw surface of kidney substance about an inch wide.

Suspecting that there might be a stone present, I passed a long hare-lip pin through the substance of the organ several times but without result. Then a large curved Hagedorn needle armed with a double

No. 8 catgut suture was passed down through one flap of the wound, then through the reflected capsule and parenchyma of the kidney and out through the opposite edge of the capsule and flap. I also passed another suture through the parenchyma alone, intending to fasten it into the flaps, but on drawing it tight it cut out through the soft kidney substance. Very little bleeding followed either this wound or the punctures. To make sure that the capsule should not slip back over the raw surface again, several catgut sutures were inserted into its cut edges and fastened to the inner surface of the abdominal wall. The wound was closed with silver sutures, a rubber drainage tube being left in the posterior angle. Antiseptic dressings were applied and the patient put to bed.

The patient had quite a severe experience for several days after the operation. Peritonitis set in, but it was skillfully combatted and overcome by Dr. Opdyke, and although convalescence was slow, everything went on well. The patient was kept in her bed flat on her back, for four weeks, when she was allowed to get up, but using a bandage and pad to prevent a relapse. After getting about she had for considerable time a good deal of pain, mostly neuralgic in character, which gradually grew less. On the 4th of January of this year (1892) I received the following report from Dr. Opdyke: "Patient apparently well except for neuralgia in shoulder and abdomen. Attends to all her school duties with ease, and takes considerable exercise."

CASE II.—The history is very brief. The patient, Mrs. G., æt. 43 years, native of United States, married and had children. Occupation, housewife. She was sent to me by Dr. Schumann, of Delhi, N. Y., with the diagnosis of movable kidney. Previous history: 22 years ago, when her second child was two months old, she first noticed some trouble in her side, but it did not cause her very much pain. Two years ago, after an attack of the grip, she began to suffer pain. The pain was sharp, in the right side, and much worse during the menstrual period, and when working or lifting. She was admitted to the Flower Surgical Hospital Oct. 30, 1891, and on examination the diagnosis was confirmed. The right kidney was easily felt in the right lumbar region, and could be easily grasped by the hand. It was very sensitive to pressure.

She was operated upon Nov. 5, 1891, in the presence of the college class and Profs. Helmuth and Doughty. Thinking to avoid the irritant effects of ether on the kidney I decided to try chloroform narcosis. Also, I thought to avoid the vomiting and the consequent wrenching of the fixation sutures. Great difficulty was experienced with the

anæsthetic, first, in getting the patient under it, and next, from the too profound effect. The patient at one time stopped breathing, and the pulse became almost imperceptible, but through energetic efforts, especially on the part of Prof. Helmuth, she reacted. Ether was then resorted to in place of the chloroform, and no further trouble experienced.

The incision was made as in the other case, except that it was nearer the last rib, the tip of which was laid bare. On account of the narrow space and a considerable quantity of fat the kidney was not as easily approached as in Case I, nor could it be pushed so far up into the wound, but by drawing it up strongly with a large tenaculum the rest of the manipulation was comparatively easy. In this case I adopted another method of fixing the organ to the abdominal wall, and instead of using catgut, silk-worm gut sutures were employed. With a large curved Hagedorn needle the sutures were passed first through one flap of the wound, then through the reflected edge of the capsule, down deep through the kidney substance, out through the other edge of the capsule and finally coming to the surface through the same flap as at the beginning. Four sutures, two in each flap, were thus introduced, except that one of them included only the capsule and not the parenchyma of the kidney, but passing across the raw surface. These sutures were not tied until the wound had been closed in the usual way with silk-worm gut sutures. Then they were drawn up and tied moderately tight. A rubber drainage tube was inserted which was removed at the end of the first week. The usual dressing was applied. The patient suffered a good deal of pain the next day and vomited several times, but after that, recovery was rapid. The highest temperature was 100.8° on the 4th day. The deep sutures were removed on the 12th day, and the remainder on the 16th day, when the wound was found to be entirely healed. She was kept in bed on her back and right side for a month, and then allowed to go about with a bandage and pad. The bandages employed in these cases were made from a pattern purchased from Butterick & Co.

The patient left the hospital "cured," on Dec. 21st, six weeks and four days after the operation. A letter from her since her return home reports her as well.

References.—Article on Nephrorrhaphy by W. B. Keen, M. D., *Annals of Surgery*, Vol. XII., P. 81.

Fagge's Practice of Medicine, Vol. II., P. 520.

Pepper's System of Medicine, Vol., IV., P. 21.

Garmany's Operations on the Cadaver.

Heath's Operative Surgery.

CÆSARIAN SECTION.

HARRISON WILLIS, M. D.,

BROOKLYN.

Having, during the last twelve months, performed laparotomy twice for obstructed labor caused by tumors in the pelvis, rendering delivery through the natural passage impracticable; and having assisted in another case in which laparotomy was performed when, imbedded between three interstitial fibroids, was found a four months fœtus, I am led to believe that there must be many such cases where the real trouble is not discovered and the patient is allowed to perish when she could be saved by an operation. The object of writing this paper is to emphasize the importance of making early, careful and thorough examination in all cases of labor. The first case will illustrate how easily we may be mistaken in our diagnosis of an abdominal tumor. We should have positive opinions, but not till we have taken all reasonable means to form them, bearing in mind that "things are not" always "what they seem."

CASE 1st.—Mrs. —, aged thirty-eight, was admitted to the Homeopathic Hospital in January, 1891, for an operation for an abdominal tumor. The patient informed us that she had been a widow for several years, and was positive that she could not be pregnant. We found by examining externally a tumor as large as a gravid uterus at full term, examining per rectum we found the tumor filling the pelvis so that the finger would just pass between it and the sacrum; anteriorly per vaginam, could just pass two fingers between the growth and the pubes, and could detect the os by bimanual manipulation above the symphysis; externally, we could outline what we thought was the uterus of normal size, a little to the right of the median line. Having a few years ago operated for an ovarian tumor where the uterus had been forced into about the same position by the tumor, I felt very sure that such was the condition in this case. An exploratory incision was decided on. On opening the abdomen we found that we were dealing with an enlargement of the uterus itself, probably fibro-cystic, and decided to remove it. A long incision was made, the uterus turned out, and an elastic ligature passed around the lower segment. Then a deep incision was made in the fundus, when an interstitial fibroid was revealed the size of a child's head. At the lower right side, somewhat

anteriorly, was found a small fibroid, almost a fac-simile of a normal uterus. It was decided to remove the whole uterus, which was done. On examination an interstitial fibroid was found in the lower posterior segment of the womb, a little larger than the upper one, and between the two, bounded in front and to the right by the smallest one, was found a four months fœtus, which was probably alive when we commenced the operation, but which could not by any possibility have gone on to maturity, situated as it was between these tumors.

The second case, where a malignant growth of the recto-vaginal septum extended above the promontory of the sacrum, throwing the cervix above the pubes, has been reported to you and was printed in the "*Transactions*" of 1891. In relation to this case I wish to state, though not in a spirit of criticism, but to emphasize the importance of thorough investigation in all cases, that physicians of great obstetrical experience had examined the patient and failed to discover the tumor.

CASE III.—At 11 o'clock A. M. on November 14th, 1891, I saw with Dr. Vose Mrs. Filkins, aged twenty-six, of 119 Somers Street. She had been pregnant ten months, had been having pains off and on for two or three weeks, which for the last three days had been quite severe, accompanied by a dark grumous discharge from the vagina. The doctor told me he was in doubt regarding the diagnosis, as he had failed to discover the os and was not at all positive in regard to the case.

On making an examination I found it to be one of those cases, if there be pathological conditions, as has been said, which are especially gotten up to deceive the "very elect," this might be one of them.

Passing my fingers within the vagina about four inches up I found what seemed at first to be the head of the child in utero. I felt for the os, it was not there; then commenced at the posterior wall of the vagina and followed it up, there was no cul de sac; then sweeping my fingers round on either side no os was found. Carrying my two fingers anteriorly they passed up beneath the pubes, and a partially dilated os was discovered. I then called the doctor aside, giving him my diagnosis, which was that a tumor filled the pelvis rendering ordinary delivery impossible, and necessitating Cæsarian section, probably; but as there was a possibility of the growth being a cyst, before operating we would introduce a trocar into it. Dr. V. made a careful examination, and agreed with me. We then told the patient and her friends her condition, and advised that she should go immediately to the hospital. To this they all strenuously objected; we told

them that we should require several doctors and two trained nurses to assist us, and that her chances for living would be much less if she remained at home, but they persisted and we acquiesced. They also asked that her former physician, Dr. Vedder of New York, should be called in with us, which request we were happy to grant. Her temperature at this time was 102, pulse about 120. We decided to operate as near three o'clock that afternoon as possible. I telephoned to Doctor Schuppan of the Cumberland street Hospital to come up with two nurses at half past two and get things in readiness for the operation. I was delayed and did not get there until half past three, when I found Doctors Vedder, O. S. Ritch and Vose waiting. Dr. Schuppan and nurses had brought order out of chaos, and all was nearly in readiness. I will state the room was small; on one side of the operating table was a stove, on the other a melodeon in close proximity. The pictures were not taken down, nor the carpets taken up, we only took pains to raise as little dust as possible. The patient was anæsthetized and placed on the table, a trocar was pushed into the tumor which was found to be solid. The first incision was made at four o'clock. The uterus was turned out when it was found that the tumor was a fibroid of the lower posterior segment of the womb. Much difficulty was experienced in putting an elastic ligature beneath the tumor, the fundus had to be drawn far over downward and much force used, as well as great care to prevent the ligature from gripping the intestines. The uterus was opened and, as we all expected, a lifeless child found, which all agreed had been dead two or three days. The womb, including the tumor, was removed and was in a gangrenous condition. The long incision was closed, no attempt was made to stitch the peritoneum to the stump, which is needless in any case but in this was impossible. The incision had been carried down a little too far toward the pubes below the stump, into this a drainage tube was inserted. The patient was put to bed and suffered but little from shock, the lowest temperature being 97°. At eleven o'clock next day the temperature was 96.6 pulse 85. The second day, when the usual flurry takes place in these cases, and owing to the extreme tension made on the stump I was expecting a great rise of temperature and pulse, the temperature was for a little while 101.2° pulse 98. The third day temperature 99°, pulse 90. For the next two weeks the temperature and pulse averaged about normal. The stump sloughed off on the sixteenth day, leaving an aperture an inch and a half deep and an inch across. Beginning at the seventeenth day the temperature was 100°, pulse 100 for two or three days. But little medicine was given.

Altogether four or five one grain opium suppositories were used, necessitating a little more opening medicine than would otherwise have been needed. In four weeks the patient was sitting up, doing as well as an ordinary confinement case. January 15th she said she felt well, was going about the house and had been out several times.

ANAL SPHINCTER STRETCHING.

WM. M. L. FISKE, M. D.,

BROOKLYN.

The modern method of forcibly dilating the sphincter ani was either unknown or unreported by such eminent surgeons as Brodie, Colles, Syme, Copeland and Calvert. They reporting in their writings of dilating by gradual measures, with bougies, tents, etc., and for the purpose of relieving strictures producing local difficulties entirely.

In 1872 Professor Simon, of Heidelberg, published an article on "The Artificial Dilatation of the Anus and Rectum for Exploration and Operation" in which he first described a method for the exploration of the lower bowel by the introduction of the whole hand; by this method he claimed that not only the pelvic organs could be explored, but that pathological changes in the abdomen could be determined. Later and more extended experience has "modified the application of this procedure, as disastrous results have followed and diseased conditions have escaped detection," which the more modern exploratory incision of laparotomy under antisepsis would have discovered. In fact with the ordinary care now taken in this latter method we have the advantage of the eye, as well as the touch, to determine the more deeply seated pathological changes that were sought for by Professor Simon and with probably less danger to the patient. The wonderful diversity of immediate and reflex conditions resulting from disease and stricture of the hæmorrhoidal inch is concisely expressed by Dr. Pratt in his latest work on orificial surgery, viz: "In all pathological conditions, surgical or medical, which linger persistently in spite of all efforts at removal, from the delicate derangements of brain substance that induce insanity, and the various forms of neurasthenia, to the great variety of morbid changes repeatedly found in the coarser structures of the body, there will invariably be found more or less irritation of the rectum or the orifices of the sexual system, or of both."

In corroboration of the many points taken by him I will simply relate some cases in my own practice worked out and experimented upon before my acquaintance with the large literature on this subject at the command of us all at this present time. In the year of 1880 I was called in to see a maiden lady thirty-five years of age, bed ridden, emaciated, hectic, distressing enuresis, sleeping only under chloral, and bowels moving only when the most powerful cathartics or enemas of two or three quarts of soap suds were used. (It is hardly necessary for me to state that these cases came to me from experienced old school physicians.) After considering and studying the case in all its lights I determined to try dilating forcibly the sphincter ani, as I had read of its benefits in constipation, little dreaming what else it would do for her. Putting her under the influence of chloroform I made my first attempt and with success, for I not only relieved the constipation but the insomnia was gradually cured, strength gradually came to her, fever passed away and emaciation gradually gave way to the gaining of flesh. At the end of six months I had to repeat the operation, and again at the end of eighteen months, since which time she has become a strong, stout, healthy woman, increasing in weight from ninety to one hundred and forty pounds. This to me was a great triumph, to her a Godsend.

The second case upon which I experimented was a married lady, forty years of age, emaciated, with a cough and hectic fever. No appreciable dullness of lungs to be discovered by either auscultation or percussion, and persistent constipation, she also complained of vaginismus and irritability of urethra; insomnia was also a distressing symptom. Two operations under chloroform six months apart made a complete cure of all the immediate and reflex symptoms in this case. I would state that in addition to the stretching of the anus, I also at the first operation forcibly dilated the sphincter vaginæ muscle.

The third case to report was a maiden lady of about forty years of age. Constipation was so persistent and the expulsive effort so inadequate, that without the use of powerful cathartics she had to assist herself by passing the finger into the vagina and forcing the fæces down and out. A complete cure was also made in this case, with but one operation under an anæsthetic.

The last case I will call your attention to was that of a young man of thirty, strong, healthy and fine physique, persistent constipation with hæmorrhoids without any reflex symptoms. One operation under anæsthesia made a complete cure.

I have repeatedly stretched the sphincter ani for simple piles and

always with good results, and always do so as a preliminary measure in all operations for extensive hæmorrhoidal tumors before excising or obliterating them. My experience has also taught me that the use of the ethyl bromide in cases requiring but a short period of anæsthesia is the pleasantest and the best.

My apology for this short resumé of some of my own work is not only to corroborate the experience of other and better surgeons but to encourage those not making a specialty of surgery to attempt this modern method for the cure of old and long standing cases that have resisted prolonged medication.

REPORT

OF THE

BUREAU OF CLINICAL MEDICINE.

THE REMARKABLE TOXIC EFFECTS OF A SMALL DOSE OF MONOBROMACETANILIDE.

J. MONTFORT SCHLEY, M. D.

NEW YORK.

Any unusual action of a drug in a dose much smaller than usually prescribed is worthy of publication. Monobromacetanilide is supposed to contain great sedative and analgesic properties, being a compound of the bromide and acetanilide, in fact it is considered infinitely superior to either drug given separately. Acetanilide has been known to possess erratic medicinal results, and it seems hard to decide whether it be due to an impure drug, and this should hardly seem possible from the cheapness of its two compounds, acetic acid and aniline, or whether the drug is liable to change its chemical character on standing or when exposed to atmospheric influences, or whether there be certain idiosyncrasies of persons in taking it. Acetanilide is prescribed usually in 15 grain doses every 3 or 4 hours with impunity.

It occurs *occasionally* to the homœopathic physician that he must seek a palliative for very painful conditions after exhausting most of the drugs which *ought* to relieve such a trouble. We know that certain intense dysmennorrhœas are only relieved by child birth or sometimes by operation. It seldom occurs—if ever—that painful menstruation due to an anomalous state of the womb is cured by drugs alone. It is in these regularly recurring troubles that these new chemical findings seem to have found a certain limited field of usefulness, but, whatever their degree of use or service may have been found to be, a *certain* danger lurks behind them all, and results occur which shock the patient's surroundings (*entourage*), and make the thinking medical man say to himself 'a trifle more and I might have killed my patient.' That the new compounds of the coal tar annually claim their own victims, I have no doubt. But for want of better, either when

administered in the fraction of a grain or in its maximum legitimate quantity, these drugs will be continued to be used (*faute de mieux*).

The case I am about to relate occurred in my own practice, the medicine was prescribed by me, and found later to have been correctly compounded at one of the most reliable drug stores in the city. I am at a loss to account for the peculiar effects of this peculiarly small dose. Imperfections of the drug were found not to exist. The only logical conclusion to come to is to attribute to it poisonous effects administered beyond one grain at certain intervals.

Miss M. ——— during the month of March, 1890, sent to my office at an early hour for a remedy to relieve her intense menstrual colic to which she was a martyr. Careful prescribing of calc-c., puls., bell., lit. tig., senecio, viburnum, etc., etc., seemed to have no result. I was confident the dysmennorrhœa was purely mechanical. On this day she begged for relief as she was giving a theater party, and in her present condition it was simply out of the question to go. I prescribed apis mel 2, and sent a recipe to obtain eight grains of monobromacetanilide to be put up in two capsules. She should take one capsule at 9.30 and if not relieved the other at 1 P. M. just before starting out. I gave her case no further thought. On returning to my office to obtain some instruments about 5 P. M., I found my young patient stretched out on the sofa in my consulting room, and her mother beside her crazed with fear. The young lady complained bitterly for want of air, she felt as if suffocating, felt pulses all through her body and limbs, her ears buzzed, constant dizziness whether quiet or in motion, a feeling of syncope constantly present, *intense* and *painful palpitation*, *nausea*, *tingling* in hands and limbs, eructations of gas, feeling of drowsiness, and on closing the eyes all her symptoms seemed doubly intensified. Her appearance was most peculiar. The face was of a faint leaden color, the eyes stretched widely open then slowly shutting for a moment to be violently thrust asunder with a staring motion, the conjunctivæ congested, the lips intensely cyanotic, the breathing 36 to the minute and superficial, pulse (144) regular and moderately full, heart's action and impulse strong, and extremities cold and blue. With it all there seemed to be feeling of impending dissolution. Naturally of a quiet judgment she seemed to have lost all control of herself. Hot bags to her body, amyl nitrite by inhalation, digitalis and brandy were administered. In about an hour she could be carried to a coupé and conveyed home. The only symptom which showed any improvement before moving her was a decrease in the number of heart beats to 120, and with the fall there came an improved tone.

I learned from her mother the following: she took the capsule as

directed, within an hour afterwards on getting up out of bed she noticed how queerly (blue) her face looked. Her mother and cousin recognized the change without having their attention drawn to it. Shortly after this, about 12 o'clock, she felt "funny," dizzy, nauseated, tingling in extremities and throbbing in head. She dressed with some difficulty, repressing her bad feelings as much as possible not to interrupt her theater party. Eat sparingly. Her menstrual colic had been entirely relieved and the flow become more scanty. On her way to the theater she could hardly contain herself, and in the building her peculiar appearance, actions and talk attracted the attention of those sitting around. She saw constantly two persons where only one was supposed to be acting, and these stood on the top of each other. She sat the piece out, and as much as she could do was to totter to the carriage and be driven rapidly to my office. After her garments had been removed I found a slight dilatation of the heart to the right. There certainly was a marked retardation of the venous flow, through a general vaso-motor paralysis or one limited to the cardiac inhibition. I should favor the latter probability.

Late that evening my patient remained about the same. The next day the pulse remained at 108, patient slept one or two hours only. Cyanosis generally better, the lips about the same, face brighter, eyes less congested, thumping and buzzing in ears still annoying, dizziness on motion, head kept very high with pillows, dyspnœa still troublesome, indigestion marked, great flow of a pale colored urine and limbs warmer. Treatment continued, on the second day all the symptoms were improving. The menstrual flow had come on again more freely with considerable pain. It was only on the fifth day she was able to get out of bed and sit up for a short while. It took several days for her circulation to return to the normal and many more before her nervous state seemed to regain its usual tones. The urine showed only a trace of albumen, $\frac{1}{200}$ of 1%, no other abnormality. Fortunately this young lady's health was good with the exception of her dysmenorrhœa and constipation.

This case has given the following points of interest:

I. Four grains of monobromacetanilide nearly produce death through cardiac inhibition.

II. A temporary relief of pain with recurrence of same.

III. Several days are required for the evil effects to pass away.

I feel confident that this young lady would have died before reaching my office had not her *heart muscle and valves been perfectly healthy.* In *all* cardiac diseases it seems that *such* remedies should be avoided, and this one especially.

Many cases have been recorded from time to time showing that moderate doses of acetanilide (15 to 20 grains) may be followed by toxic symptoms, and recently one case is cited where an ounce of this drug had been taken. Aniline is supposed to contain the toxic properties of acetanilide. It has been thought therefore that poisoning by aniline or acetanilide would closely resemble each other.

Dr. Hartge, of Dorpat, compares the case of a student who had taken 28 to 29 grammes of acetanilide for a cold with Dr. Dehio's case of poisoning by 154 grains aniline. In the latter case the toxic result consisted in blue coloration of the skin and mucous membranes, profound coma lasting for several days, irregularity and quickening of the respiration, acceleration of the pulse, the smell of aniline in the breath, loss of power of motion, considerable disturbance of the sensory powers, followed by jaundice, with anæmia, albuminuria and hæmoglobinuria. Possibly this aniline was impure and contained toluidine, which is nearly always found in the aniline used for commercial purposes and in that employed by bacteriologists for staining tubercle bacilli. In Dr. Hartge's case aniline to the extent of ½ of an oz. was contained in the poisonous dose of acetanilide. This was twice as much as that taken by Dr. Dehio's patient; notwithstanding this Dr. Hartge's case presented no loss of consciousness, of motion or of sensation, no albuminuria or hæmoglobinuria, and only the slightest trace of jaundice; the blood-corpuscles, too, presented their normal appearance and character, there being no detritus or specks of pigment, though the color of the blood was changed to a dark blue, as in aniline poisoning; also the respiration was rendered rapid and irregular and the pulse accelerated. The patient complained of great inability to sleep, and the cardiac palpitation and dyspnœa produced a feeling as of impending death. Dr. H——. on seeing the patient was struck by the marked blueness of the skin, which was general over the whole surface but especially dark in the eyelids, the chin, and the temporal regions. The general appearance was quite different from that of cyanosis. Vomiting came on. Stimulants, coffee, soda draughts, camphor in ether hypodermically and applications of cold compresses to the head were employed. On the third day the patient was able to leave his bed, and the blue color had quite disappeared. Dr. H——. who obtained Prof. Dragendorff's assistance in the working out the case, remarks that the acetanilide must have been a remarkably pure specimen.

In comparing the symptoms of the two foregoing cases you must note many (symptoms) differing from those met in my case both as to extent, parts affected and intensity and persistency of same.

REPORT

OF THE

BUREAU OF MATERIA MEDICA.

HAS IT BEEN AN OVERSIGHT?

M. W. VAN DENBURG, A. M., M. D.,
FORT EDWARD.

Is there a therapeutic law plainly deducible from the facts alleged in allopathic materia medica, if the same methods are applied that are used to demonstrate natural laws in other departments of investigation?

This is not, nor can it be made, a hackneyed question until it has been decided at the bar of scientific deduction. Too much is at stake in the welfare of the race, in the advancement of the science most important to humanity—the science of preserving life—to dismiss this consideration with a shrug, a smile or a sneer.

If our allopathic confreres have been blundering along where they might have walked safely, confessing (as they have been and still are by the mouths of their best men) that there is no general guide or rule for the administration of drugs, and if such a law has lain unrecognized upon the open pages of their text-books for years, awaiting for its demonstration only the application of the same general rules that apply to the demonstration of natural laws in other departments of scientific research, then surely the most effective way of meeting their objections is to convince them of the existence of such a law out of their own mouths. This must be done, not in one or two, but in multiplied instances; not occasionally, but repeately and continually, until they are forced to acknowledge at the bar of public opinion the futility of denying its existance.

In this line was prepared the "Study of Arsenic," presented to the International Homœopathic Congress at Atlantic City in 1891. In

further illustration of the method this paper is now brought forward for your consideration.

All the facts alleged are from allopathic sources, from the recognized authority—Stillé's Therapeutics and Materia Medica.

Let me beg your indulgence to call attention to some general principles laid down in the paper on arsenic to which reference has been made.

First, the general principles laid down by Herbert Spencer for finding a natural law. He says: "Though we can never learn the nature of that which is manifested to us, we are daily learning more completely the order of its manifestation. 'The order of manifestation' is but another expression for that constant course of procedure which we call law." (Spencer's First Principles, Chap. Laws in General, 1864.) In chemistry, when sulphuric acid and metallic zinc are brought in contact for a sufficient length of time sulphate of zinc will be produced. This is a "constant course of procedure." In physics, when two metals are connected by a copper wire, or other conductor, and placed in a solution which acts chemically upon one of them and not upon the other a current of galvanic electricity is generated which will pass over the connecting wire in a certain direction; this is an "order of manifestation" always present. At or near the earth's surface all unsupported bodies tend to fall towards the earth's center. This is a "constant course of procedure," the "order of manifestation" of the phenomena of falling bodies. Whenever we find "a constant course of procedure," we find a natural law.

Two series of phenomena are set forth by Stillé, as by all allopathic writers on materia medica; the one is termed "The action of the drug on man," the other "The remedial employment of the drug."

What we most desire to know, what every physician desires to know, is: can any "constant course of procedure" be laid down for the *administration* of drugs?

The allopathic answer to this is, there is no "constant course of procedure" known. The problem seems *not* to have been approached from the side of scientific experiment guided by the scientific method. There has been plenty of experimentation in a desultory way, but without the application of the scientific method. The experimental side of drug action has been and still is being developed, but not with the careful precision the subject demands: it has noted only the most prominent, which are far from always being the most important facts in the application of the drug in medicine. Out of this array of experimental facts each author has felt at liberty to choose or reject as

his own discretion might dictate. But with all this, the question seems never to have seriously suggested itself: what is the relation, if any, which exists between the phenomena of the action of the drug on man, and the curative action of the drug in disease? Obviously, the only way to find out is by comparing the two series of phenomena.

For this purpose we now turn to the study of asafœtida, all the facts used being, as stated, from Stillé.

It may be well to say at this point that all the facts or symptoms given by our author under the action of the drug on man have been quoted here, as also all the cures reported and all the diseased states for which it has been recommended in its remedial employment. On this account all failures of the two series to conform will become apparent in the comparison.

In the digestive sphere, asafœtida causes:

"Burning in the fauces;

"Impaired digestion;

"Enfeebled digestion;

"Alliaceous eructations;

"Oppression and fullness of the stomach;

"Nausea and vomiting;

"Distention of the abdomen and discharge of fetid flatus;

"Colic and burning in the abdomen;

"Increased peristalsis of the bowels;

"Strong inclination to stool;

"Diarrhœa;

"Thin and repeated evacuations;

"Increased secretion of the liver;

"Removes intestinal worms."

Asafœtida cures:

"Impaired digestion;

"It augments the appetite;

"It improves the digestion;

"It improves the morbid secretions of the mucous membranes, and expels intestinal worms;

"It cures distention of the abdomen by promoting the discharge of flatus;

"It cures hypochondriasis by the direct action of the drug on the digestive function, which is the starting point of the disease."

We note that no disease is here said to be cured by the drug that has not its direct counterpart in the diseased state caused by the "action of the drug on man." Even the expulsion of worms falls under this

head, since it is conceded that intestinal worms are the result of an impaired state of digestion and not the associates of the healthy human being.

In the respiratory system, the action of asafœtida causes:

"The pulse and the respiration to become slower;

"The pulmonary exhalations to become increased;

(Note in the last, the careless and indefinite method used in describing the action of the drug.)

Asafœtida cures:

"Chronic catarrh, with or without spasmodic dyspnœa;

"When the wheezing is considerable and the expectoration difficult from the general debility, or the cough spasmodic, much benefit may be derived from the use of the drug."

In the sphere of the nervous system, asafœtida causes;

"General malaise;

"More or less flying pains in the head;

"Various nervous and hysterical phenomena."

(Again we regret the imperfect report of the action of the drug as expressed in the description of the hysterical phenomena.)

"Occasionally asafœtida increases the sexual desire;

"It tends to hasten the menses;

"General debility is cured by the property of this drug of imparting vigor without excitement;

"This drug is one of the most valuable agents that can be employed in the treatment of hysterical cases;

"In the true epilepsy it is perfectly useless, but in hystero-epilepsy it is reported to have cured one case;

" In nervous apoplexy, or that form which seems to consist in simple congestion of the brain, it deserves a prominent place;

"The spasmodic affections of girls at the age of puberty are frequently cured by the establishment of the menses; the emmenagogue properties of asafœtida may therefore become the indirect means of removing these nervous disorders."

Again note, no cure is here mentioned as affected by this drug (except the indirect cure,) but a like diseased state is caused by the drug in its action on man.

But a still stronger case in the same direction is made by our author. Look on these two pictures.

Asafœtida causes:

"Impaired digestion; general malaise; enfeebled digestion; colic and burning in the abdomen; distention of the abdomen; (Jorg says

'enormous distention of the abdomen,' and Jorg is the authority quoted by our author;) and various hysterical phenomena."

Says Stillé:

"In that torpid condition of the bowels which is commonly associated with general debility, when digestion is imperfectly accomplished and severe attacks of colic supervene, when tympanitis, sometimes of an immoderate degree, oppresses the breathing and becomes the exciting cause of any hysterical attack, when at the same time there are signs of chlorosis or that disease is fully developed, a combination of symptoms is presented which causes extreme suffering to the patient and great annoyance to the physician. No single medicine is more useful than asafœtida in removing this."

Can it be possible we are not reading the prescription of a dye-in-the-wool Hahnemannian homœopath, one of the strictest of the sect?

When Stillé talks of a "combination of symptoms removed by a single remedy," and when every symptom in that combination, (with the exception of one, which one may or may not be present) is found in the list of symptoms caused by "the action of the drug on man," what more could Hahnemann himself have advised in such a case?

Surely the assertion of Hahnemann that "when the totality of the symptoms of the patient are matched by symptoms of a like degree and kind caused by the action of a drug on the healthy human organism, then that drug will assuredly cure the patient"—if it needs confirmation, Stillé furnishes as strong testimony for it as sound reasoning and candid thinking could ask.

We therefore note, in applying Spencer's law, that the "order of manifestation" of the curative power of this drug as shown by "the constant course of procedure" in effecting cures (as set forth by Stillé's therapeutics) in those diseases without exception which are strongly similar to the morbid states produced by "the action of the drug on man," and that *no other cures* are recorded, or recommended, save in one case only where the cure is declared to be "indirectly made."

PROCEEDINGS

OF THE

Forty-first Semi-Annual Meeting, held in New York, October 4th and 5th, 1892.*

President WILLIAM M. L. FISKE called the meeting to order at 10.45 Tuesday morning in Jaeger's Hall, corner of Madison Avenue and 59th Street, and prayer was offered by Rev. J. Erskine Adams, of Brooklyn.

GEO. G. SHELTON, on behalf of the County Society, welcomed the visiting members to the city.

President FISKE: It is a great pleasure to all of us, after the anxiety of the last few weeks, to meet here on the forty-first semi-annual meeting, and to realize that we are gathered together in the healthiest city in the new world. It is a great satisfaction to know that after the trying summer that we have passed through, many of you have found the time and the opportunity to prepare papers for our benefit, for our encouragement, and for our enlightenment, and it is a pleasure to say that the bureaus are full enough of material to occupy every single minute of our time with the reading and discussing of the papers. While many of us have been resting quietly at the seashore or in the mountains, while many have crossed the ocean, away from this country entirely, through all the heat, through all the anxieties and perplexities of life, the Legislative Committee have kept steadily at work, and with our loyal and royal Paine as the standard-bearer, they have prepared a plan of campaign for the autumn and winter months which should and must elicit the sympathy and co-operation of every single member of this society, as well as of every member of our profession practising in this state; and I can assure you that we are to be entertained by a jolly good lot of fellows in this city. They have spared no time or pains or money in seeing that we are well cared for, and I wish to one and all that the days that are spent here, away from your practice, may be red letter days to all of you, to which you will revert for many seasons to come with pleasure and with profit.

The doctor then read his Presidential Address.

---

*Stenographer, Wm. C. Huson.

THE ADVISABILITY OF LAWS FURTHER REGULATING MARRIAGE.

Appreciating the custom of making our semi-annual meeting purely social and literary in its character, leaving to the annual gathering at Albany the details of purely business matters relating to the interests of our society, my address at this time will be somewhat removed from the ordinary lines usually followed by your presiding officer, and upon a subject that has impressed itself upon my attention very forcibly for some years.

Leaving to the intelligent chairmen and members of the different bureaus the work coming under their respective sections, setting aside the usual commendations and arguments in favor of our particular school of medicine, passing over the usual eulogiums to our time-honored Hahnemann and the long line of brilliant names that will always stand as shining lights in the cause and work of homœopathy in the ages to come, as they have in the years that have passed, I shall simply furnish food for reflection and action on the part of all of us as physicians, and more especially for our redoubtable Committee on Legislation, composed as it is of some of the most notable natural-born fighters and aggressive men to be found in any such committee in any medical society of whatever school in this country.

To-day none can appreciate more than the residents of these two great cities how greatly we are dependent upon the medical profession for our preservation from a death-dealing scourge that is threatening our homes and our firesides. One man, and he the health officer of the port of New York, has held in check a plague that threatens thousands of precious lives and puts in jeopardy millions of capital. He represents the careful and scientific work of men who have devoted their lives to the laws governing health and disease, laws that have been formulated by physicians and approved by wise legislation, principles that carry out the best and most brilliant methods of true preventive medicine, and when we realize that all the laws that control and govern the hygiene and sanitation of all our great commercial centres are the outcome of careful and intelligent research and experimentation by men connected with our chosen profession, well may we be proud of our work for the amelioration of the sufferings of humanity, even if through corrupt and inefficient public officials our advice often goes unheeded and filth is allowed to breed its pestilential nidi in our streets and market places.

The exquisite sentimentalism of many of our legislators who would disfranchise a part of our native born Americans on account of peculiar

cuticular pigmentation, and tickets and photographs a portion of the most industrious, law-abiding and peaceable of our immigrants yet allows pauperized Europe to send its anarchistic, nihilistic and socialistic-breeding out-casts, to land on our hospitable shores almost unchallanged, may have to be educated up to our standard to appreciate the suggestions herein contained for more advanced legislation in the laws governing marriage, a branch of preventive medicine yet untouched, except in its crudest form, in this progressive land of ours. For *to-day*, as the law stands, only the idiot and the raving maniac, who in the eyes of the law are not responsible for contracts made, are forbidden marriage. No matter how much diseased, crippled, deformed or instinctively criminal, there is no bar to marriage and to the propagation of a suffering, helpless family.

Can any of us look upon this as a healthful outlook for our future generations? But the time *will* come when this subject will receive careful consideration from our law makers.

It is already thoroughly appreciated and acted upon in a land we almost consider semi-barbaric. I refer to the States of Brazil, where strict laws governing marriage are in full force.

There are very serious questions coming up to be considered by our political economists, as to the care of the unfit in our rapidly growing population, and we as physicians are in duty bound to give of our knowledge and experience, such advice in the formulation of laws that shall at least help to stop the pauperism and crime so fearfully on the increase, and which taxes the honest breadwinners to support and care for.

Dr. Henry Dwight Chapin, in a recent article in the *Popular Science Monthly*, says: "It is of pregnant interest to study the destructive factors at work in society that not only produce the unfit, but also tend to their survival. This question derives its principal significance from the apparently hopeless task of dealing with the unfit. Science and theology from widely divergent poles, appear to reach much the same conclusion with regard to delinquents.

"Darwinism and Calvinism present about an equally hopeful consideration for the unfortunates of our race. One says heredity and environment; the other predestination and foreordination. Both suggest the witty aphorism of Dr. Holmes that the proper time to begin the treatment of some diseases is a hundred years before birth."

Certainly there is cause for alarm, and vigilant research for the remedy, when we look at the ratio of increase to the population in each decade. The population increasing 30 per cent.—the defective or unfit, 150 per cent.

Mrs. Lowell (*Christian Union*, August, 1891), estimates that the number of paupers in the public and private institutions of New York city alone, totally supported at any one time, is about 28,000. The cost of maintaining them during 1890 was $3,794,972. She further states that if you go back forty years we find that the increase of contributions of public funds to private persons for the support of private paupers, has been from $9,863 in 1850, to $1,845,872 in 1890, and that the amount is nearly two hundred times what it was forty years ago. The increase of expenditure for public paupers through the hands of public officials has been at a much less ratio, increasing from $421,882 to $1,949,100 during the same interval of time. Further statistics as to the grand work being done by private individual subscriptions and the use of public funds from the general tax-payer in caring for the "poor that are always with us," can be easily given, but the great question that we are trying to and must solve, is how to *prevent* the increase of the unfit, and I shall try to point out where our duty lies in the formulating of laws that shall select proper parentage for the generations that are to come after us.

Heredity is responsible for many of the diseases and much of the crime and pauperism of our communities. Maudsley says: "There is a destiny made for a man by his ancestors and no one can elude the tyranny of his organization."

Dr. Benjamin West says: "The first step toward the reduction of disease, is beginning at the beginning to provide for the health of the unborn. The error commonly entertained that marriageable men and women have nothing to consider except wealth, station or social relationship demands correction. The offspring of marriage, the most precious of all fortunes, deserves surely as much forethought as is bestowed on the offspring of the lower animals."

Dr. S. A. K. Strahan, in a recent work on marriage and disease says: "It is a question how far the present evil state of things should be allowed to go before the strong arm of the law should interfere."

When we realize what an immense amount of capital is invested every year for the improvement of our live stock, even our dogs, and then see with what blind, thoughtless, wicked recklessness people enter into marital relations, the contrast makes it appear absolutely criminal. And it is not confined alone to the ignorant and thoughtless, for one can easily recall instances where physicians have married invalids. Only a few months ago, in this city, a worthy son of a most noted sire, married his neurasthenic patient and started on his wedding trip for the benefit of her health. It is absolutely impossible for a man with a

neurotic constitution marrying a woman of like organization begetting healthy progeny.

It is our duty to point out wherever and whenever possible the dangers of heredity, and the teachers in our schools and colleges should be thoroughly posted that they may impress upon the young the necessity for purity in everything relating to their lives. And yet with all the advice, all the pleading, and all the warning that you and I may give to those about to enter the married state, a puling sentimentality, that "love should go where it chooses" is back of all, and unless the strong arm of the law is still back of that, our advice ninety-nine times out of a hundred is set aside and incongruous marriages are consummated that are an outrage upon posterity.

This society has not for years at any of its meetings been left in chaotic ignorance of the origin, care, needs, abuses and future prospects of the insane in this state, yet for my own purposes I shall inflict upon you the very latest report of the Census Bureau, which states that the whole number of insane persons treated in both public and private institutions during the year 1889, was 97,535; while during the year 1881, there were 56,205 treated, showing an increase in the nine years of 41,330, or $73\frac{53}{100}$ per cent.; these figures do not include the mildly insane and idiotic, cared for in their own homes.

Dr. Selden H. Talcott, in reply to an inquiry from me, states that for the past eight years there were admitted to the Middletown Asylum, 931 males and 905 females; of this number there were 276 males and 341 females with hereditary tendencies to insanity; and of all the most dreaded, worse than death, yes a living death in itself, and one that parents try to conceal in every manner possible from the public eye.

Who of us has not seen a lovely girl married and with her first child develop puerperal mania, perhaps to recover from this first attack, then with her second child become still more violent and perhaps incurable. She has surely passed the taint to her offspring, yet possibly and probably her young husband had no knowledge of the danger that was lying in wait for her and for him.

A law should be passed forbidding marriage in a family where insanity is known to exist on either or both sides for at least one or two generations. If it is necessary that two qualified physicians and a judge shall decide upon the sanity of one to be committed to an asylum, why should not the law provide that two qualified physicians shall decide the propriety and right of suspects and all persons contemplating entering the conjugal state.

This same precaution should be taken regarding the marriage of

epileptics, for it is certainly one of the most fearful diseases that attack man and one that is (except the result of accidental injury) most distinctly of hereditary origin; Strahan states in words better than I can write, that "It may be truly said of the epileptic that he is doubly cursed. Racked in body, and robbed of mind, he soon becomes the most pitiable creature on earth. If he is so unfortunate as to survive, to escape all the pitfalls which his disease spreads in his path, too often he is only spared for a worse fate; for the intellectual fate of the epileptic between the seizures is always a downward one. If life be sufficiently prolonged the same dark destination is reached whether the downward journey be a gradual descent or be accomplished by a series of bounds, each marked by an outburst of murderous frenzy. In either case the goal is a depraved imbecility. As a hereditary disease it is on a footing with suicidal impulse, melancholia, drunkenness and gout."

It is unwise in an address like this to detail proofs, but it is an easy matter for any one to find proof for all that I state, and laws enacted for the prevention of marriage of epileptics under any condition or circumstances are justifiable and will eventually be enforced.

"The morbid craving for alcohol is common, and so intense that men who labor under it will gratify it without regard to their health, their wealth, their honor, their wives, their children, or their soul's salvation. After they have become dipsomaniacs, in the present state of the law that does not allow legal interference with their liberty, I say it with deliberation—the sooner they drink themselves to death the better. They are a curse to all that have to do with them, a nuisance and a danger to society, and propagators of a bad breed."—T. S. Christin, M. D., "Mental Diseases."

The pitiable condition of the confirmed drunkard may be described never so forcibly, the pencil of a Doré may portray never so fearfully but that we as physicians can show counterparts in the experiences of our practice. Who of us have not seen a generous-hearted, open-handed fellow, in spite of all warning, gradually sink down from a commanding place in social and business circles to the lowest depths of degradation, disease and death, through alcoholism. And I think that with all our experience, and it has a chance for full sweep, when one of our great dailies stated in its columns only a few weeks since, that one hundred thousand wretched lives in this city alone, made so by alcoholism, were dragging out a miserable diseased existence that would only be relieved by death. As I say, I hardly think we give heredity its full credit for this horrible condition, ascribing most of our drunkenness in men and women to perhaps incidental or accidental surround-

ing influences, or as more tersely expressed, environments. This subject has, however, been studied out perhaps more thoroughly than any other vice that inflicts us—for it is not only the field of research for the social scientist and the anthropologist, but it is in the hearts of women all over this land who have heard the cries of their agonized sisters, and with intelligence, zeal and persistency worthy of angels, have and are trying to look into every cause and root out in every possible way this evil. During the past thirty years of rather an extended professional experience I have seen numbers of lovely young women, despite all pleadings, in their deep love and delusion, marry drunkards with the fond hope that the reform they had failed to accomplish during their courtship would be consummated after marriage. I have yet to see the first successful experiment, and I have seen all the miseries of a drunkard's home follow.

My object at this time is not how to reform or how to care for these poor unfortunates,—this is a subject outside of my present purpose, but it is to call the attention of our law-makers to the fact that a confirmed dipsomaniac should be debarred from marriage. One example from Morel in his "Traité des Dégenéréscencés," will give a fair idea of hereditary taint in this disease.

"First generation, the father a drunkard.

"Second generation, son a drunkard, who was disgustingly drunk on his marriage day.

"Third generation, seven grand-children. First and second died of convulsions. Third an idiot at twenty-two years of age. Fourth melancholic with suicidal tendency; became demented. Fifth, peculiar and irritable. Sixth, has been insane repeatedly. Seventh, nervous and depressed and indulges in most despairing anticipations as to his life and reason.

"A child twelve years of age, by no means ugly or repulsive, who, when questioned by the Judge, remained self-possessed, lucid and child-like, with a fondness for cakes and sweets, to procure means to indulge her appetite enticed a little child who wore gold earrings up to the second story of her house, relieved her of her earrings, then threw her from the window, killing her, so that she could not point her out as the one who robbed her as she knew her victim could not talk sufficiently well to accuse or mention her name. She expressed no contrition or emotion in any way. She was intelligent beyond her years, but had no sense of what she had done, and was morally an idiot.

"A boy of fifteen, a small, ugly-looking lad, small head, low forehead, sullen aspect, squint of left eye, dull at his books, but not a bad or

untruthful lad and had no vices. Other boys made fun of him and his little sister ten years of age doing the same. One day when he had been left quietly sitting alone with his sister in his father's shoe shop, brained her with a shoe-hammer, then he locked the back door as he always did on leaving home, and went out closing the front door after him. He returned after an hour, wet from the rain which had begun to fall, was taken to prison and from the first displayed no emotion. He ate and slept well, and was a good docile boy. These are examples of instinctive criminals, who having served their terms of imprisonment as child murderers, can as men and women, marry.

"The so-called 'Jukes' family is the largest criminal family known, and its history, which has been carefully studied, is full of instruction. The ancestral breeding place of this family was in a rocky inaccessible spot in this state. Here they lived in log or stone houses, sleeping indiscriminately around the hearth in winter like so many radii with their feet to the fire. The ancestor of the family, a descendant of early Dutch settlers, was born between 1720 and 1740. He is described as leading the life of a backwoodsman, "a hunter and fisher, a hard drinker, jolly and companionable, averse to steady toil," working by fits and starts. This man lived to old age, when he became blind, and he left a numerous more or less illegitimate progeny. Two of his sons married two out of five more or less illegitimate sisters; these sisters were the 'Jukes.' The descendants of these five sisters have been traced with varying completeness through five subsequent generations. The number of individuals thus traced reached 709; the real aggregate is probably 1,200. This vast family, while it has included a certain proportion of honest workers, has been on the whole a family of criminals and prostitutes, vagabonds and paupers. Of all the men not twenty were skilled workmen, and ten of these learned their trade in prison, 180 received out-door relief to the extent of 800 years, or making allowances for the omissions in the record, 2,300 years. Of the 709, there were 76 criminals committing 115 offences.. The average of prostitution among the marriageable women down to the sixth generation was 52.40 per cent. The normal average has been estimated at 1.66 per cent. There is no more instructive study in criminal heredity."—A Study in Crime, Pauperism, Disease and Heredity," by R. L. Dugdale.

"The instinctive criminal, in his fully developed form is a moral monster," Havelock Ellis in the "Criminal."

In 1889 there were 31,000 long-termed prisoners in the United States. One-half upon beginning their terms of imprisonment being diseased or of imperfect health.

We cannot in these days of civilization drown the miserable product of these classes, as we would a bad litter of pups in a horse pond, but laws *can* be formulated that will prevent procreation when the instinctive criminal is so adjudged.

Why should young men in our cities, who, under the guise of "sowing their wild oats," and tacitly winked at in their lecherous and drunken debauches and orgies, contracting syphilitic and gonorrhœal poison, acquiring habits of dissipation, inflict their diseased bodies, corrupt minds and depraved hearts upon the pure and untarnished daughters of our households without even a warning from the law, yet we as physicians are criminals in the eye of the law, subject to fine and imprisonment if we attempt to destroy the ovum in utero of these broken down debauchers which we know if left to go on to maturity can be nothing but beings innocently predestined to lives of suffering and disease. The law allows the rachitic, distorted and deformed girl to marry, and the physician is called in as a legitimatized murderer to destroy her unborn offspring, to save *her* life, when the law should have said, Thou shalt not marry. And so on with the young and immatured, the scrofulous, the tuberculous, and the cancerous diathesis.

Sentiment allows and promulgates the legitimate increase and survival through their children of these scourges of the human family. *Sentiment* encourages the marriage of deaf mutes only to increase the care and burden upon the tax-payers. It is a noble and generous impulse of the human heart to provide homes for consumptives and the old and infirm, hospitals for crippled children and those suffering with cancer; asylums for our insane and orphans. Yet beyond all this it is more humane to save innocent children from a bad heredity, and the sooner laws are passed restricting indiscriminate marrying, and proper restrictive measures enforced for this purpose with penalties attached for a violation of the laws, the sooner will certain diseases be restricted and annihilated and pauperism and crime diminished.

This subject is a profound one and the material at our command unlimited for study, but I shall close, submitting this new field for work to our Legislative Committee to take the initiative in this, as they have done in the higher education of our profession.

The following committees were announced:

Committee on Attendance—E. Hasbrouck, J. W. Dowling, L. A Bull, E. J. Pratt.

Committee on President's Address—F. Park Lewis, G. W. Winterburn and E. E. Snyder.

The Secretary read the minutes from advance sheets of the Transactions, and they were adopted.

The Secretary read a notification from the Treasurer that ALDEN GIFFORD was dropped for failure to qualify, in accordance with By-Law II, §2, ¶4.

A letter of resignation from JAMES L. WATSON, of Brooklyn, was read and on motion, the resignation was accepted.

A letter was read from F. E. ROPER, now of Pueblo, Col., stating that the writer had paid his dues eighteen months ago and sent in his resignation previous to moving out of the state. The explanation and resignation were accepted.

REPORT OF THE BOARD OF CENSORS.

The following 36 new members were elected :

ADAMS, MYRON H., M. D., Rochester, II*, 1870.
BIRDSALL, T. P., M. D., Patterson, I, 1878.
BLEECKER, WM. H., M. D. Brooklyn, I, 1887.
BROWN, M. BELLE, M. D., New York, III, 1879.
BUCHHOLZ, LOUISE Z., M. D., New York, III, 1886.
BURDICK, MRS. ALICE H. M. D., New York, IX, 1872.
CAMPBELL, E. E., M. D., Alexandria Bay, V, 1885.
CARLETON, B. G., M. D., New York, I, 1876.
COOKE, MRS. HARRIET N. F., M. D., New York, III, 1868.
CORWIN, ELIZABETH, M. D., Binghampton, III, 1892.
DEMAREST, J. H., New York, XI, 1865.
DOTY, GEORGE H., M. D., Brooklyn, I, 1884.
DOWE, FRANK LE C., M. D., New York, I, 1889.
FAY, RUSSELL, P., M. D., Yonkers, I, 1887.
FOSTER, WM. E., A. M., M. D., Bay Shore, I, 1891.
GORE, JENNIE E.. M. D., New York, III, 1885.
HANFORD, HAROLD W., M. D., New York, I, 1890.
LANE, IRVIN J., M. D., Sing Sing, I, 1883.
MADDEN, JOEL D., M. D., Sing Sing, I, 1876.
MARTIN, G. FORREST, M. D., Skaneateles, I, 1890.
MCDOWELL, GEO. W., M. D., New York, I, 1886.

*I, New York Hom. Med. Col. and Hosp.
II, Hahnemann Med. Col. and Hosp. of Philadelphia.
III, N. Y. Med. Col. and Hosp. for Women.
IV, Hahnemann, Med. Col. and Hosp. of Chicago.
V, Chicago Hom. Med. Col.
VI, Hom. Col., Univ. of Mich.
VII, Cleveland Hom. Hosp. Col.
VIII, Col. of P. & S., N. Y.
IX, Eclectic Col. of N. Y. City.
X, Indiana Eclectic Med. Col.
XI, H. Med. Soc. of the Co. of N. Y.

McMICHAEL, D. A., M. D., New York, I, 1890.
MOSSMAN, N. A., M. D., New York, I, 1861.
VON MUSITS, HENRY, M. D., New York, I, 1878.
POWELL, LEFFERTS M., M. D., Chatham Centre, X, 1892.
RITCH, AMOS M., M. D., Brooklyn, I, 1886.
ROBINSON, E. H., M. D., Ontario, Can., VII, 1888.
ROCKEFELLER, H. O., M. D., Brooklyn, I, 1887.
STORER, J. H., M. D., New York, I, 1891.
SWETT, EMILY F., M. D., Medina, IV, 1885.
WALLACE, WM. I., M. D., Montgomery, VI, 1884.
WEED, ROBERT M., M. D., New York, I, 1880.
WETMORE, JOHN McE., M. D., New York, VIII, 1855.
WILCOX, F. P., M. D., Clifton Springs, II, 1886.
WILLIAMS, FRANK FAY, M. D., Canton, I, 1883.
WILLIS, HARRISON, Jr., Brooklyn, I, 1892.

THE REPORT OF THE COMMITTEE ON ATTENDANCE

showed a registration of 129 members and 30 visitors, including Drs. C. F. Adams, delegate from the New Jersey Society; H. M. Biggar, Ohio; W. B. Van Lennep and B. F. Betts, Pennsylvania; T. Y. Kinne and C. A. Church, New Jersey; W. S. Morrison, New Brunswick, Canada.

Albany County—Geo. E. Gorham, H. M. Paine.
Broome County—Elizabeth Corwin, Lynn A. Martin, E. E. Snyder.
Chautauqua County—D. G. Alling.
Chemung County—F. W. Adriance.
Delaware County—Carl Schumann.
Erie County—L. A. Bull, F. Park Lewis, D. G. Wilcox.
Fulton County—W. S. Garnsey.
Kings County—Gertrude G. Bishop, Wm. H. Bleecker, R. Boocock, W. M. Butler, F. E. Caldwell, E. Chapin, G. B. Cornell, Lottie A. Cort, G. H. Doty, Wm. M. L. Fiske, D. A. Gorton, C. H. Hadley, E. Hasbrouck, J. T. W. Kastendieck, W. C. Latimer, H. B. Minton, John L. Moffat, R. C. Moffat, Ward C. Pardee, O. S. Ritch, N. Robinson, H. O. Rockefeller, J. E. Russell, W. S. Searle, Hugh M. Smith, S. Talmage, A. von der Lühe, A. G. Warner, H. Willis, H. Willis, Jr.
Madison County—Myron H. Adams, N. M. Collins, W. E. Deuel, E. H. Wolcott.
Monroe County—E. J. Bissell, J. M. Lee.

New York County—T. F. Allen, H. J. Ball, A. Berghaus, C. C. Boyle, M. Belle Brown, Louise Z. Buchholz, Bukk G. Carleton, J. Oscoe Chase, B. G. Clark, L. L. Danforth, J. E. L. Davis, Chas. Deady, J. H. Demarest, Geo. M. Dillow, F. E. Doughty, F. LeC. Dowe, J. W. Dowling, C. Eurich, J. B. Garrison, Lewis Hallock, Wm. Tod Helmuth, Henry C. Houghton, Wm. Harvey King, J. F. Land, Malcolm Leal, Abby H. MacIvor, Chas. McDowell, A. R. McMichael, D. A. McMichael, R. E. McMurray, W. S. Miner, N. A. Mossman, Henry vonMusits, A. B. Norton, F. J. Nott, J. T. O'Connor, H. I. Ostrom, H. Worthington Paige, C. G. Pease, W. I. Pierce, E. H. Porter, E. J. Pratt, G. W. Roberts, J. M. Schley, G. G. Shelton, G. A. Shepard, Henry M. Smith, St. Clair Smith, J. H. Thompson, Irving Townsend, E. G. Tuttle, G. E. Tytler, Phebe J. B. Waite, J. McE. Wetmore, A. Lenora White, J. Ralsey White, George William Winterburn.

Oneida County—F. F. Laird.

Onondaga County—J. W. Candee, E. E. Keeler.

Orange County—Geo. Allen, F. A. Jacobson, Selden H. Talcott, Wm. I. Wallace.

Oswego County—J. H. Keeney.

Putnam County—T. P. Birdsall.

Suffolk County—W. E. Foster, A. J. Woodruff.

Tioga County—J. T. Greenleaf.

Tompkins County—C. E. Van Cleef.

Warren County—S. T. Birdsall.

Westchester County—E. V. Brown, R. P. Fay, Irvin J. Lane, J. D. Madden, D. J. Roberts, R. R. Trotter, E. P. Swift.

Connecticut—A. J. Givens, E. H. Linnell.

Canada—E. H. Robinson.

On motion, it was voted that the reading of papers be limited to 15 minutes each, and each speaker, in discussion, to 10 minutes.

President FISKE read an invitation to the ladies in attendance at this meeting to a reception Wednesday afternoon by Mrs. William Tod Helmuth at her house.

BUREAU OF PUBLIC HEALTH.

In the absence of Chairman Seward, J. W. Dowling presented two papers:

* "The Necessity for a National Quarantine under Federal Control," by J. M. Schley.

* Read by title.

"A Plea for Justice," by J. W. Dowling.

On motion adjourned.

The members of the society, upon invitation of the Faculty of the New York Homœopathic Medical College and Hospital, were driven in a number of Fifth Avenue stages to the college buildings where, after an inspection, they were served with a nice luncheon. All hands then adjourned to the operating amphitheatre of the Flower Hospital* where, after one or two brief addresses, Dr. Helmuth conducted a surgical clinic, exhibiting a few patients, operating for external anal fistula and reducing a luxated joint.

All of the arrangements of the committee in charge worked smoothly and promptly, and the members were returned to the hall in time to begin the afternoon session promptly at 2.35 P. M.

FIRST DAY—AFTERNOON SESSION.

BUREAU OF CLINICAL MEDICINE.

W. S. Garnsey, chairman, submitted six papers:

"Some Observations upon Bright's Disease, especially Interstitial Nephritis," by F. F. Laird.

"Chorea, Three Clinical Cases," by L. A. Frazier.

"Asthma a Result of Pleuritic Effusion," by W. S. Garnsey.

"Verification of *Culex Musca* (Mosquito)," by B. L'B. Baylies.

"Prognosis in Organic Heart Disease," by J. M. Schley.

BUREAU OF MATERIA MEDICA.

George G. Shelton, chairman.

T. F. ALLEN presented verbally a report of provings of *Cedron*, which the stenographer failed to take. The speaker was surprised and disappointed in that repeated careful experiments failed to elicit any periodicity, any neuralgia, or any reliable subjective symptoms. "My provers emaciated slightly; their urine was increased, and there was marked increase of all its constituents, especially of urea. I do not believe *Cedron* will prove useful for uræmic poisoning although in the provings it has shown that it certainly increases urea. I tried it in two cases of albuminuria with low urea, but without any result whatever.

* Built and supported by Governor Flower.

BUREAU OF PÆDOLOGY.

"The Leucorrhœa of Children," by Georgia A. Cassidy.

* "Stomatitis," by J. Oscoe Chase.

MISCELLANEOUS BUSINESS.

JOHN L. MOFFAT: Seven years ago this society printed a circular warning mothers, nurses and physicians of the dangers of purulent ophthalmia and giving directions for guarding against its resulting in blindness. Year before last a law was passed at Albany requiring the nurse or parent to report to a physician any inflammation of the eyes in a new-born child. Every oculist in the state must have had, as I have, numerous cases of ophthalmia neonatorum resulting from violations of this law, undoubtedly from ignorance of it. It would seem properly within the functions of this society, and of its Committee on Legislation, to do something toward educating the community in this respect, and how better than by printing and distributing copies of the law in question (it is very short) with brief directions for cleansing the eyes? I therefore move the adoption of the following:

Resolved, That the Committee on Legislation be instructed to have printed and distributed the text of the law† which requires midwives, nurses, relatives or guardians to report without delay to a physician all case of inflamed eyes in the new-born. *Voted.*

On motion adjourned.

In the evening the members of the society with their wives and daughters were royally entertained by a banquet at Sherry's which far eclipsed anything of the kind in the history of this society or of the American Institute of Homœopathy; our hosts, the New York Homœopathic County Society, fairly out-doing themselves in lavish elegance and hospitality.

SECOND DAY—MORNING SESSION.

President FISKE called the meeting to order at 10.45 A. M. Wednesday, October 5th, and extended the courtesies of the floor to Dr. CHAS. F. ADAMS, delegate from the New Jersey Homœopathic State Society, and to Drs. H. M. BIGGAR, of Ohio, T. Y. KINNE and C. A. CHURCH, of New Jersey, and W. B. VAN LENNEP and B. F. BETTS, of Pennsylvania.

* Read by title.

† L. 1892, c. 325, §3, (which also repeals c. 41, L. 1890, "An Act for the prevention of blindness.")

REPORT OF COMMITTEE ON PRESIDENT'S ADDRESS.

Your committee beg leave to report that they have listened with deep interest and profound satisfaction to the thoughtful, scholarly, and well considered paper that has been presented to this society and that they find themselves fully in sympathy with the suggestions which have been so clearly and successfully put forth. They feel that the advanced studies in heredity and in criminal anthropology which have so conclusively demonstrated the possibility of foreseeing physical, mental and moral conditions and of modifying them, should be recognized in our legislature, and that it is through the medical profession that this influence should be exerted.

Your committee feel, however, that the subject is one so profound in its nature, so wide reaching in its ramifications and so important in its conclusions, that any legislative suggestions should be made with unusual care and deliberation.

They would recommend, therefore, that a committee be appointed (the President of this society being its chairman), to formulate specific suggestions to be presented at the next annual meeting and which may then in due form be presented to the Legislature.

F. PARK LEWIS,
G. W. WINTERBURN,
E. E. SNYDER.

On motion the report was adopted and the committee discharged.

President Fiske later in the day appointed on the committee thus called for, Drs. F. Park Lewis, W. S. Searle, and George M. Dillow.

BUREAU OF GYNÆCOLOGY.

E. E. Snyder, chairman, offered the following five papers, besides two or three that were held over to the next annual meeting or were presented under the next bureau.

"A Case discriminating Malposition of Kidney from Pelvic Growths," by A. Lenora White.

"The Responsibility of the Physician in the treatment of Obscure Pelvic Disorders in Woman," by B. F. Betts.

"Drainage after Laparotomy," by H. I. Ostrom.

"The Rectal Mucous Membrane as a Means of Preventing Infection in Operations about the Anus," by W. B. Van Lennep.

"A Case of Pudendal Hæmatoma," by F. W. Adriance.

BUREAU OF OBSTETRICS.

George William Winterburn, in charge, presented five papers :

" Position an Important Factor in the Management of Parturient Cases," by W. H. Proctor.

" The Forceps and Occipito-posterior Positions," by E. H. Wolcott.

*" My Experience with the Female Perinæum," by J. H. Hallock.

" The Fourth Stage of Labor," and *" The Perinæum in its Relation to Normal Labor," by George William Winterburn.

SECOND DAY.—AFTERNOON SESSION.

The Society convened promptly at 2:30 p. m., and proceeded directly with the

BUREAU OF MENTAL AND NERVOUS DISEASES.

J. T. Greenleaf, chairman, reported three papers :

" Special Therapeutics of Static Electricity," by Frank E. Caldwell.

" Orificial Surgery in the Cure of Mental Disease," by C. A. Church.

" The Colonization of Epileptics," by W. M. Butler.

By unanimous consent the floor was given to HENRY M. SMITH, who addressed the society upon a bronze

STATUE OF HAHNEMANN,

which the American Institute of Homœopathy proposes having erected in Washington by means of subscriptions on the part of the laity as well as of our profession throughout the country. About a thousand dollars were subscribed in Washington in less than half an hour, when there were but few present.

There is but one statue of Hahnemann in the world, the one at Leipzig, and that is a poor one hidden away in a small park.

It is the intention to erect in Washington a statue to which we can all point with pride, designed by some sculptor of renown, and based upon the bronze bust a copy of which was presented by Madam Hahnemann to the Institute in 1876.

It is important that the homœopathists in all of the states be thoroughly organized, and I move the appointment of a committee to aid the Institute committee.

*Read by title.

The President, duly authorized by vote of the society, subsequently appointed:

William M. L. Fiske, R. C. Moffat, B. L'B. Baylies, William Tod Helmuth, Henry C. Houghton, George A. Cox, S. N. Brayton, Asa S. Couch, H. M. Dayfoot, Jay W. Sheldon, and W. H. Watson.

BUREAU OF LARYNGOLOGY AND RHINOLOGY.

H. Worthington Paige, chairman, announced six papers:

"Rational Treatment of the Throat and Nose," by L. A. Bull.

"Adenoid Growths in the Nasopharyngeal Space," by J. M. Schley.

*"Ulcerative Rhinitis following Diphtheria," by M. W. Van Denburg.

"Treatment of Hypertrophic Rhinitis," by C. E. Teets.

*"Syphilis of the Mouth and Throat, with Treatment," H. Worthington Paige.

*"Diphtheria," by J. B. Garrison.

BUREAU OF OPHTHALMOLOGY AND OTOLOGY.

A proposition was made to hold a sectional meeting for this bureau, but was overruled.

H. D. Schenck, chairman, presented seven papers:

"Observations with Javal's Ophthalmometer," by E. J. Bissell.

"Reflex Neuroses from Eye-strain," by A. B. Norton.

"Treatment of Hyperphoria," by E. H. Linnell.

"Ulcer of the Cornea cured by Chinin-Mur," and "Dislocation of the Lens," by A. G. Warner.

*"A Case of Nuclear Iridoplegia," by C. C. Boyle.

"Sound as a Factor in the Treatment of Diseases of the Sound-conducting Apparatus," by Henry C. Houghton.

BUREAU OF SURGERY.

Harrison Willis, chairman, announced five papers:

"Suturing the Tendo-Achillis," by DeWitt G. Wilcox.

"Fracture of the Base of the Skull with Delayed Symptoms," by H. B. Minton and H. P. Sage.

"Three cases of Appendicitis (?)—No Appendix," by Sidney F. Wilcox.

---

* Read by title.

* "The Removal of Facial Blemishes by Electricity," by William Harvey King.

* "Promiscuous Cases," by Harrison Willis.

MISCELLANEOUS BUSINESS.

JOHN L. MOFFAT gave notice of proposed amendments to the By-Laws to the following effect :

By-law IV, §2, add : "It shall be the duty of each bureau (subject to consultation with the Executive Board) to decide which papers shall be read before the society. The chairman of the appropriate bureau shall, in ample time before the meeting, put the papers so selected, or abstracts of them, into the hands of certain members that the latter may prepare themselves to lead in their discussion."

By-Law V, add §3 : "No paper shall be read before this society unless it shall have been placed in the hands of the (proper) bureau chairman at least two weeks before the meeting."

If there has been any drawback to this meeting it has been lack of time to read and adequately discuss all of the papers presented. An effort—as usual, unsuccessful—was made to get the papers into the hands of the chairmen in sufficient time for preparation, but quite a number have been brought to the meeting without warning and this with the large number on hand has caused matters to be rushed through. Some papers could well be read by title, others in abstract, while a large number should be heard in extenso.

On motion of the Secretary, the society unanimously voted its hearty thanks to the New York County Society and the College for their unstinted hospitality and for the promptness and smoothness with which all their arrangements were carried out.

J. M. SCHLEY, of the Legislative Committee, presented a bill for postage to the amount of $3.94, which, on motion, the Treasurer was ordered to pay.

COMMITTEE ON LEGISLATION.

GEO. E. GORHAM : At the beginning of the year the Middletown asylum was left filled with pauper patients ; the physicians throughout the state and the homœopathic taxpayers were complaining that it was impossible for them to secure homœopathic treatment for the homœopathic insane of this state. Your committee immediately began work to obtain the needed relief. We have been hard at work by correspondence, by frequent interviews, and by one general meeting in Buffalo, in deciding upon some plan by which the homœopathic insane in this state could be cared for and the asylums be managed by

the homœopathic fraternity instead of by the Commission in Lunacy in Albany. We have decided upon a plan which we hope may be successful, namely, to introduce into the Legislature this winter substantially the same bill that was introduced last winter for the relief of Middletown, and also a bill which will provide for the rights of the homœopathists for all time in caring for the insane of this state. This plan is in the hands of the secretary of the committee who will be glad to read it.

H. M. PAINE presented by title a paper "The Constitutionality of the Law creating State Medical Boards upheld by the Court of Montana and by the Supreme Court of the United States" and submitted a supplement to his record (presented at the last meeting) of the proceedings of the State Board of Medical Examiners.

GEORGE ALLEN read by title a paper, "The Situation at Middletown," and E. H. Wolcott offered the following resolutions, which were adopted:

WHEREAS, There being no room at the Middletown State Hospital for the admission of insane patients (for whom homœopathic care and treatment is desired) coming from fifty-three of the counties of this state; and

WHEREAS, No provision is made for such care and treatment at any of the other public insane hospitals in this state; and

WHEREAS, The civil right of choice of medical treatment is inviolable, equitable, essential, and consonant with the principles of sound government; therefore

RESOLVED, That in the opinion of this society such legislation is an immediate necessity as will provide:

First. For the early restoration of the Middletown Hospital to its original purposes and uses, that of the homœopathic care and treatment of those for whom homœopathic treatment is desired.

Second. For the early establishment of such other State Homœopathic Hospitals as may be required in other parts of this state, the evidences thereof to be obtained by data furnished by members of the homœopathic profession therein.

Third. The appointment of a State Homœopathic Commission in Lunacy, which commission shall be provided with the same powers of commitment and control of homœopathic cases and institutions as the present commission in Lunacy has over non-homœopathic cases and institutions.

RESOLVED, That the Committee on Medical Legislation is hereby instructed to take such action as may be required to secure the proposed legal enactments.

On motion adjourned.

JOHN L. MOFFAT,
Secretary.

REPORT

OF THE

BUREAU OF PUBLIC HEALTH.

"The Necessity of a National Quarantine under Federal Control," - - - - - - - - J. MONTFORT SCHLEY.
"A Plea for Justice - - - - - - - - - - J. W. DOWLING.

THE NECESSITY OF A NATIONAL QUARANTINE UNDER FEDERAL CONTROL.

J. MONTFORT SCHLEY, M. D.,

NEW YORK.

The few remarks I have to make will be directed towards our national safety—not only for the year to come but for all time. My remarks cannot reasonably be retrospective in view of the scenes recently enacted in our lower bay and along the shore of Long Island. Quarantine, in times of epidemics and when in danger of threatened epidemics, is a matter of expediency. Very few of the medical profession oppose quarantine in toto. If they differ, it is in the degree of quarantine to be enforced and by what authority to be carried out. There can seem to me no doubt of the necessity of a quarantine for this country, but, there should be one head—and one head only, and one supreme power and one power only, to enforce the law alike for New York, Massachusetts, Pennsylvania, Louisiana, California, etc.

What good can come to us if our New York quarantine laws be all sufficient and our neighbors, are deficient? How are we to keep an intruder from the premises if by making a slight détour he can get in through an open back door?

How is this scourge to be stopped if he finds his only opposing forces fighting among themselves, i. e., the medical commander of the Marine Service and the Health officer of the Port?

The question finally to settle is, how can we go about it to make our quarantine most usefnl, most practical, most beneficent, more protective and more humane?

It appears to me that this can be only accomplished by one supreme authority and this must be carried out by the Federal government through its surgeon-general and Marine Service.

It should have arbitrary rights over any and all laws that a State may make or has made. It is most probable that they can work in harmony, and where the State law is inefficient the Federal government should supply that want.

We look to our government to provide means for our protection in time of war, we look to her to equalize economic, financial and legislative matters, and surely her citizens and dependants have the right to look to her for intrenching means against a foe which is far more deadly than one which comes with the thundering of cannon and the bugle call. This country can never be safe from visitations of the plague until an equal, obstinate indomitable and courageous front is shown it wherever and whenever it may appear.

It would do away—in a measure—with the panic and the terror the populace have of this disease if they knew a firm, steady and perhaps incorruptible service was looking out for their welfare. Nay, more than this—if they perchance have studied the methods of dealing with this pestilence in countries like England—they (the populace) would never cease their demands until an equal protection were offered them. It will and must come to this—and it would seem to me that we are only at the beginning of the question of the limitations of personal liberty for the general good of society at large. In a national quarantine the administration of the law could be carried out with mingled firmness, some sympathy and a perfect system.

History tells us that cholera has reached New York on more occasions than one through other sources than our harbor.

It seems strange, in a country with such an extent of territory and unbounded resources as ours, and accustomed to the wholesale arrival of emigrants from all parts of the world, that some safe place for their temporary detention should not have already been provided, with a due regard also to their health, comfort and food-supply.

For the present neither the discovery of the comma bacillus nor the anti-choleraic inoculation of M. Hoffkine will practically avail us anything in the way of prevention. The plain duty before us is to adopt measures of proved efficacy and apply them in a similar way to what we should do in the case of any other epidemic disease, and not to

supplement evils which are unavoidable by others of our own production, or establish nurseries for the development of cholera by crowding together numbers of poorly fed, and in some instances half-starved, frightened suspects—as recently occurred—into unwholesome and disease-breading quarters.

We must endeavor to inculcate certain precepts and practices in regard to cholera, and to state what we know and what we still require to know about it from three different aspects, viz., as a pandemic or branch of epidemiology, on the one hand, by surveying the facts connected with its extension on a large scale, over vast tracts of country and amid different populations; and, on the other, as to its spread on a small and limited scale, by studying its progressive steps in a circumscribed community made up of a limited number of individuals, and further to learn the limitation and advantages of certain systems of quarantine. We can deduct facts on these premises which seem to be warranted by our past experience and present knowledge. Quarantine —per se—is not alone to be relied upon. We would urge that the safest guard against cholera is public sanitation in its broad sense, and in its application to individuals accompanied by a vigilant observation and inspection of all shipping and immigrants arriving in this country from infected and non-infected European ports. The first is not only effectual against cholera, but against any other epidemic disease. The latter should imply in this country suitable arrangements for the isolation of all cases of cholera or suspected cholera that might be landed, and the isolation in a different locality—on land—of passengers by infected vessels until a certain limit of time has expired. They should be detained longer if unable to give any precise address in view of their being kept under notice and their subsequent medical history traced and observed. Quarantine, it seems is a matter of expediency on this continent, but in England where it seems in a measure to be of a perfunctory nature—cholera, under the most encouraging circumstances seems to have been unable to find a lodgment. How can we explain this fact? It seems attributable alone to her wonderful sanitary conditions and precautions. Cholera has been introduced at numerous places and ports in that country, but no outbreak or epidemic has ensued. It may be that the measures adopted have arrested its progress. It may be that an epidemic manifestation of its activity is only suspended for a time, but the fact remains. At present England is free of cholera notwithstanding that the disease has prevailed in France since April last, and that there has been free and constant communication between the two countries, and notwithstanding that

she has a larger, more direct, constant and, it may be said, organic connection with the home of cholera than any other country, she has nevertheless suffered less than any other nation in Europe.

These facts should give us food for reflection. The valued reports of the late Dr. Dryden while statistical officer of India contain a mine of information on this subject. He claims that an epidemic of cholera lasts between three and four years from start to finish. We are in our first year now.

In closing, I would offer as a resolution, that this society pronounce itself unreservedly in favor of a national quarantine under Federal control.

A PLEA FOR JUSTICE.

J. W. DOWLING, M. D.,

NEW YORK.

In connection with the work of the Bureau of Public Health, I desire briefly to call the attention of the society to a matter which is of importance, not only to the homœpaths of this city, but also to the adherents of homœopathy throughout the state. I allude to the desirability and necessity for providing in the City of New York a hospital for contagious diseases which shall be under the control of homœopathic physicians. It has long been a hardship that in this metropolis there is no place where a patient, stricken with one of the more virulent contagious diseases, may be taken and placed under the care of physicians practicing homœopathy.

With epidemics of such malignant character as those of the past eight months liable at any time to break out, as a result of the immense pauper immigration which has, until recently, been going on, and which will undoubtedly be resumed in the near future, the danger of contracting one of these diseases is by no means small. Suppose a believer in homœopathy to be attacked by such an illness. What would be the result? He would be sent at once to the Willard Parker Hospital for Contagious Diseases. Here, though he would undoubtedly receive the best possible nursing, yet he would be given medicinal treatment which he had been brought up to distrust, and subjected to a system of therapeutics abhorrent to his ideas of scientific medicine.

We all know that without faith in the remedies, the patient often fails to derive benefit; nay, the very lack of confidence acts unfavorably upon the course of the disease. How important it is, then, that one should not be deprived of that sustaining influence, the knowledge that one was receiving the treatment which one believed most likely to prove successful.

This rule of the New York Board of Health is an absolute one, and has no exceptions. No matter where a case of typhus should occur, no matter how prominent the physician in charge, the patient would be sent to the place provided, as above described. Only after an epidemic had reached considerable proportions, and the patients in that case proving too numerous to be handled and provided for by the means and men at the command of the health officers, would the homœopathic physician be permitted to retain the care of those of his patients contracting the disease.

Again, in the case of the less virulent, or rather less dreaded contagious diseases, such as scarlatina, diphtheria, &c., occurring among those residing in hotels or boarding houses, the same thing occurs. The patient, will he, nill he, is placed under the control of Old School physicians in the public hospital. To the question, "Is this right, is this common justice?" there can be but one answer, and that a negative.

In the care of the souls of those under their control, the Board of Health shows greater fairness. Religious consolation and comfort may be given by the adherents of any faith to the occupants of the hospitals, asylums and jails, but when it comes to a mere question of bodily welfare, our authorities say: "No; we will do all we can for you, but whether or not there is anything better, we do not admit its existence, and you must sink or swim on our advice. We will not even give you the plank you ask for, with which to try to swim ashore yourself; not even if you let us say when and how you shall use the plank, and in which direction you shall swim."

This is the attitude of those in authority in this city, and all we outsiders can do is to hope that we may never be stricken with a contagious disease and brought into their power.

There are good reasons why this state of affairs should exist no longer. It is admitted that "Taxation without representation" is a political crime. Who supports the hospitals controlled by the Old School? The entire community, the funds being derived from taxation. Who will deny that men, believing sincerely and honestly in the principles of homœopathy, pay a large share of these taxes? But where does the representation come in? The Old School physicians

are in absolute control. The Board of Health, under their influence, has absolute command of the funds, and autocratic power over the bodies of those sick with contagious diseases. And those of the sick who happen to think that there might be something better than the treatment they receive under allopathic care must grin and bear it, and pray that their constitutions may prove strong enough to withstand the treatment on top of the disease. It cannot be conceived that a rational mind, uninfluenced by bigotry and jealousy, could take any other view of the justice of this claim.

We have other reasons, and good ones, for pressing our claim to be allowed to look after our own cases of contagious diseases. The most convincing is the inspection of the tables of the mortality in various epidemics. Take cholera for instance. In one of the late epidemics in Germany there were so many cases that they were obliged to send many to the homœopathic hospitals. The government inspector, avowedly hostile to this system of therapeutics, was compelled to report to his superiors that, while in the hospitals under so called "regular" treatment two-thirds of the patients died, in the Homœopathic Hospital, on the contrary, two-thirds of the patients got well. In London during the last epidemic the same thing occurred. The inspector was here obliged to report a death rate in the city hospitals in cases of cholera of 60—70 per cent., and in the homœopathic hospital a mortality of 25—40 per cent. The Old School authorities give the death rate in typus at 10 per cent. in mild epidemics, while in the London Homœopathic Hospital in an epidemic of 36 cases but two died. What Old School figures can compare with those of Dr. Williams, of Bristol, England, in the epidemic of small-pox in 1872. He treated 300 cases with but 19 deaths, a percentage of 6⅓.

These again are convincing arguments to all except those who fear they will lose their bread and butter by competition with the new school.

You may say, this is a matter in which the homœopaths of New York City alone are concerned. Not so, gentlemen. You will all admit that annually a large proportion of your patients visit this city. Will you go back to your work and be willing to say to your patients that it was a matter of no concern to you what became of them or who took care of them, should they be so unfortunate as to contract cholera, typhus or small-pox while stopping at one of our hotels? You know you would not, and for this reason I bring this matter to the attention of this society, that it may, by its influence help in the accomplishment of this purpose. We have influence and we can use

it, and let me impress upon this society that the times are favorable for obtaining the realization of our wishes. The recent and to a certain extent present excitement over the probability of an epidemic of cholera, has set people to thinking. It must have been brought home to every homœopath, even physicians, "what will become of me, if I happen to be one of the first to be attacked?" I know that visions of the black ambulance of the Willard Parker or Floating Hospitals, and worse than all this, the terrific treatment, medical of course, in store for me if I happened to fall into the hands of our friends, the enemy, have crossed my mind many times in the last month. Can you realize that unless you encountered an unnusually good natured hospital physician, under such circumstances, you would not be allowed to take a single dose of veratrum or camphor or cuprum, and that you would be sent at once into a state of semi-unconsciousness by the opium you would receive! If people of influence who believe in homœopathy quite realized all thus, there would be a homœopathic hospital for contagious diseases in New York within three months. Another favoring circumstance is that we have just won a governor who has distinguished himself by the display of a magnificent spirit of humanity, and by the exhibition of much sterling common sense. In addition he is a believer in homœopathy and places his health and that of his family in the hands of one of our members. Would he not be likely to affix his signature to any legislative act granting us this hospital? Again we have but recently shown our power in the Legislature. Were not the strongest efforts made to place the licensing power in the hands of a board, a majority of whose members should be openly hostile to us and our school, and did we not succeed in defeating those efforts, and obtain for ourselves equal privileges. Is it not probable that legislation, mandatory in form, could be obtained, whereby this hospital could be established and *supported*. We must not forget that this latter point is most important. We do not want a hospital without funds and find ourselves in the position of perennial beggars to help support it. When the cholera or typhus scare had subsided it would be as hard to raise funds for this as for any other hospital, and many of you know how hard that is. No, we should have as a right a share in the moneys raised by taxes which we help to pay, and of this share we should control the use and distribution.

Another favorable circumstance is that the present Board of Health did through its President Mr. Charles S. Wilson give the permission that in the event of an epidemic of cholera the homœopaths might establish emergency hospitals for the treatment of cholera and might

treat patients there and at their homes, in case the epidemic assumed large proportions. All honor to these gentlemen, for let me tell you that in every preceding epidemic of cholera in this city this same request has met with a flat refusal. But this provision, of course, could be but temporary. A succeeding board, or the same board, could rescind such action and we would be again left in the lurch. The danger of cholera is not over and the prospect of its return next summer not very remote. This permission should during the coming winter be made the law. Application should be made to the legislature by the County Society and it should be backed up by all the influence of this society for a law chartering a homœopathic hospital for contagious diseases in New York city and providing that the Board of Estimate and Apportionment should appropriate the money necessary for the proper maintenance of such a hospital. This seems to be the only way to attack this problem. Private subscription will not do, for until the law is changed the present law gives the Board of Health absolute control of every patient and his treatment if attacked by a contagious disease. We might build the hospital but we could not take patients to its wards. Of course, it is not desired to restrict in any way the powers of the Board of Health as to quarantine, isolation, disinfection, etc. What homœopath would be unwilling to give all possible assistance in such matters? It is in the one item of medicinal treatment that we ask fair play.

I think I have established my points, viz:

First—The necessity for such a hospital.

Second—Good reasons for establishment now.

Third—Reasons for its endorsement and support by this society, and

Fourth—That the times are ripe for obtaining our object.

It can only be hoped that those in position to do so will take this matter up and carry it to a satisfactory conclusion.

DISCUSSION.

R. BOOCOCK: Something should be done to educate the public as to the importance of this matter.

REPORT

OF THE

BUREAU OF CLINICAL MEDICINE.

"Some Observations upon Bright's Disease, especially Interstitial Nephritis," - - - - - F. F. LAIRD.
"Amyl Nitrite in Heat Flushings," - - - - H. M. HICKS.
"Chorea," - - - - - - - - L. A. FRAZIER.
"Asthma, a Result of Pleuritic Effusion," - - W. S. GARNSEY.
"Verification of Culex Musca (Mosquito)," - - - B. L'B. Baylies.
"Prognosis in Organic Heart Disease," - - J. MONTFORT SCHLEY.

SOME OBSERVATIONS UPON BRIGHT'S DISEASE, ESPECIALLY INTERSTITIAL NEPHRITIS.

F. F. LAIRD, M. D.,
UTICA.

A recent medical writer bluntly expressed a familiar truth when he wrote "The grippe seems to possess the power of arousing all the latent 'cussedness' in the human anatomy." Its baneful influence upon previous cardiac disease is known to every physician; its equally pernicious effect upon latent renal lesions seems to have attracted far less attention. This oversight may possibly be due to the fact that many a case of apoplexy, phlegmonous inflammation and gastro-intestinal catarrh have been diagnosed as diseases per se rather than symptoms or complications of the insidious interstitial nephritis. Such an error can rarely befall the physician who makes it a rule to carefully examine chemically and microscopically the urine of every chronic patient; but he who neglects these precautions will often find, to his chagrin, that he has been fighting the pickets while the enemy has captured the fort. As applied to the diagnosis of interstitial nephritis, the usual tests for albumin (heat and nitric acid) are, as commonly employed, a snare and a delusion since the small amount of

albumin present in this form of renal lesion is often passed by unnoticed. This fact has been so often brought to mind during the last year in a somewhat extensive experience with this class of cases that I cannot too emphatically emphasize it. In the urine of two patients who were under my care up to the time of their death and where the diagnosis was confirmed by microscopic examination of the kidneys, no trace of albumin could be detected by the most delicate tests except at rare and infrequent intervals. Indeed the cases of nephritis without *persistent* albuminuria are by no means so extremely uncommon; and to this class belong, I am thoroughly convinced, a considerable percentage of the deaths of people over 60 years of age following the two epidemics of 1891–2 and variously certified as "heart failure," "general debility," "apoplexy," "chronic diarrhœa," "hæmorrhage," etc.

A symptom in the male has so frequently called my attention to incipient interstitial nephritis that I am inclined to regard it as of great value in pointing to this lesion before any other sign is prominently manifest, viz., impaired or lost sexual power. This varies all the way from slight diminution of sexual desire to complete impotency. During the last two years I have, in every case, made careful inquiry for this symptom and have so often found it present that its genuineness cannot be questioned. Its significance is fully as pronounced as in diabetes and probably owes its origin to a cause common to both diseases. It is worthy of note in this connection that glycosuria sometimes, as in one of my cases, complicates albuminuria and thus renders the dietetic treatment of the latter anything but an easy task.

Chronic nephritis occurring in a patient previously suffering from "spinal irritation" frequently manifests itself in such a peculiar manner as to mystify the most acute diagnostician. In these cases, the full symptomatology seems to so center upon the spinal cord that the physician is almost forced into the belief that there must be present a meningo-myelitis to account for the severity of the symptoms. There are various neuralgic pains shooting out through the several spinal nerves. Occipital and intercostal neuralgia, gastralgia, enteralgia, sciatica, et cetera, may alternate like the ever changing pictures in a kaleidoscope. Numbness and even "girdle pains" may be present; and yet there is no actual paralysis. Palpitation of the heart, dyspepsia and asthma appear in frightful intensity; but auscultation of the chest reveals no organic disease. In all the cases which I have seen—three in number—the ordinary flatulent dyspeptic symptoms have been notably absent until a very late period of the disease. The spinal

irritability seemed to be independent of the amount of urea passed, but was markedly aggravated whenever a too highly nitrogenized diet was used. The presence of an undue amount of uric acid in the urine was invariably the harbinger of a severe neuralgic storm. The patients from whose history the foregoing description is drawn were all males of nervo-sanguine temperament. One had acquired his irritable spine as a result of cerebro-spinal meningitis; in the other two it was secondary to severe falls upon the coccyx. Medical literature, so far as my reading goes, makes no special allusion to this class of cases, which are certainly very unique.

Whenever a large number of remedies are recommended in the treatment of a given disease one may safely conclude that most of them are practically worthless. So we find it in interstitial nephritis. "Many are called but few are chosen." One remedial measure, however, has in my hands nobly stood the crucial test of clinical experience and given results far more satisfactory than any drug with which I am familiar. I refer to the systematic use of the hot air bath. The apparatus employed is Rouchetti's, over which is placed a wire cage invented by one of my ingenious patients to protect the bed-clothing from scorching. A description of the apparatus, method of using it, etc., may be found in Millard's "Bright's Disease," p. 217, et seq. The frequency of the bath is regulated by the exigencies of the case and varies from twice daily to once a week. After the first trial, profuse perspiration is generally easily induced in from 15 to 20 minutes, and is continued from 30 to 60 minutes according to the patient's strength. Gin is given before the bath to prevent any feeling of faintness which might possibly be induced by the heat. After the bath, the patient is rubbed dry, bathed in alcohol and water, equal parts, and then wrapped in hot woolen blankets. By this means, the danger of taking cold is effectually averted. For a long time I shared the common fear of administering this bath except to vigorous patients. A more prolonged experience, coupled with a rapidly lessening dread of alcohol in nephritis, has thoroughly convinced me that the cases in which its effects are anything but salutary are extremely rare. Given under the eye of a physician or carefully trained nurse, no danger need ever be apprehended. It is far safer and far more effectual than the hypodemic injection of pilocarpine which so often produces distressing nausea and vomiting.

AMYL NITRITE IN HEAT FLUSHINGS.

H. M. HICKS, M. D.,
AMSTERDAM.

In offering the following to the consideration and criticism of the New York State Homœopathic Society I do not claim to discuss anything new, simply clinical facts.

CASE I. Mrs. S., aged forty-nine and married, came under my care in August, 1888. She had suffered from heat flushings for a number of years and during that time she had grown worse. She went abroad for a year to regain her health, but to no purpose. She was very nervous, digestive powers weak and generally debilitated in every way, but the symptom she complained of most was the hot flushes, which, as she said, "burned her up." My first prescription was lachesis 6^{x} alternated with cim. 3^{x} every two hours. She returned in three days saying she was no better. Gave her amyl 1^{x} dil. 3 drops once in three hours. She reported in two days that she felt better. Remedy continued. At the end of one week she reported that she felt about the same. I now prepared amyl, drachm 1, and alcohol, drachms 2, in a solution, and gave her three drops of this once in three hours. I gradually increased this in the next two weeks until I gave her five drops of the crude drug once in four hours. At this time the flushes had entirely ceased and she quickly regained her health and has remained well since.

CASE II. Miss K., aged thirty-seven, nervous temperament, came for treatment in January, 1891. She complained of hot flushes about the pelvis and in the neck and back, but more especially the eyes. These, as she expressed it, "felt as if on fire." Her periods were regular and no trouble in that direction. Appetite and digestive powers normal. She had been troubled with the above symptom for about six months. She had not been treated for it. I gave her one-third of a drop of amyl once in two hours, and she made a complete recovery in less than a week.

CASE III. Mrs. M., aged fifty, and a widow, had passed the climacteric for more than a year. She was anæmic and badly run down. But in spite of her impoverished condition the one great symptom she complained of was the hot flashes which extended over the whole body to the very finger tips. I adopted all the means possible to build up her general health; she improved finely in every-

thing but the flushes, which still continued. I used all my efforts to cure her of this symptom, but not until I had used the amyl could I give relief, and then it came as perfect and complete as in the two former cases.

I will not attempt to analyze or theorize on the action of amyl; it can be found in our therapeutics, where its action and uses are exhaustively explained. It is a sovereign remedy in angina pectoris, as I can well attest.

The above cases were taken from among several others as illustrative only. In them I obtained the most marked results. Most of the others were entirely relieved by the remedy, but in some I had to carry the dose to five drops or more of the crude drug. I do not wish to be understood to have depended upon this alone; special symptoms were met by the indicated remedy, and in all the reconstructive was adhered to. Everything to build the patient up, and in this, as in most other chronic cases, I find most trouble to properly nourish my patient. In commencing the treatment I now always begin with one-third of a drop of the crude drug once in two hours and, for fear of its physiological action, I have the patient take to her bed for about five minutes each time.

Before closing I wish to call the attention of the society to a remedy which, so far as I am informed, has but a limited place in our materia medica. It is the aspidosperma quebracho blancho, commonly known as quebracho. This is a remedy of considerable value in diseases of the respiratory passages. It seems to me somewhat similar in its action on the throat and bronchi to drosera, but its action is more profound, for it is an arterial depressant. But it is its action on dyspnœa of all kinds that I wish to speak. I have used it in spasmodic croup, asthma, and the dyspnœa arising from organic heart disease, with good success. It had the least action in croup, although it is certainly palliative. In asthma it is proved to be almost a specific in relieving the distressing effort at respiration. I have used it in the 1[x] dil. in croup, but find that asthma requires from five to twenty drops of the fluid extract to give relief. I should like to hear from other members of the society who, I have no doubt, are better informed as to its action than I.

DISCUSSION.

GEO. E. GORHAM: I have used amyl nitrite in chorea and nephritis with satisfactory results.

CHOREA—THREE CLINICAL CASES.

L. A. FRAZIER, M. D.

AMSTERDAM.

CASE I. Was a young girl thirteen years old, very bright and active. Had a good family history on the father's side, but on the mother's side of the family there had been the history of a long line of scrofulous swellings. This girl had infantile eczema during her first dentition which began simultaneously with her first tooth at three months of age. When two and a half years old she had scarlet fever, which left her with acute ophthalmia and suppurative inflammation of the middle ear. The ophthalmia yielded to treatment, but was followed by suppurative inflammation of the glands of the neck, which continued six or eight months.

Although she had never menstruated and did not until more than a year after recovery, she was in fair health previous to her first and only attack of chorea. The disease was allowed to run two weeks without any treatment, when she was scarcely able to walk or even eat without assistance. Her appetite was good but it was difficult for her to chew her food.

The motion of her limbs and face and even her head and trunk was almost constant during the day, but ceased entirely during the night. I prescribed perfect rest from all study and every kind of work, plenty of outdoor air, and a liberal amount of easily digested nourishing food. I gave her zinc val. 3^{ss}, one two-grain tablet every four hours during the day. She was entirely well in three weeks.

CASE II. Was a boy nine years old. This patient lived out of the city several miles in another county. An old nurse of mine and grandmother of the boy gave me the following history: Both parents were healthy. This boy was their only child. He had been sick several weeks and had been under the care of one or two allopathic physicians all the time, and was rapidly growing worse. She was now going to her daughter's to help take care of him until he became better or died. He was very constipated, had little or no appetite, was losing flesh very fast, and unless he could get some relief very soon could survive but a short time. The contortions of his face and the convulsive movements of both upper and lower extremities were painful to see.

I told her to keep him from all excitement and to keep him in as perfect a state of rest as possible; give him plenty of fresh milk and fresh air. I sent him zinc val. 3^{x} to be given, one two-grain tablet, every four hours excepting when he was asleep, and when he was able bring him to my office. In one week from the time of commencing the treatment I received a very thankful letter, stating that the boy was very much improved, and in another week they brought him to my office. I found him quite thin in flesh, but the contortions of his face had entirely ceased, and the jerking movements of his limbs were only slight. I continued the treatment with the addition of nux vom. 2^{x}, one drop in a teaspoonful of water three times a day before meals, as he was still constipated. In two weeks more I had another letter telling of the delight of the parents and that the boy was as well as ever and attending school regularly. This was two years ago. I have seen the parents since and they say he remains perfectly healthy.

CASE III. Mrs. G——, twenty-two years of age, married. I was first called to attend this case on the 23d of June, 1892. I found her in bed, her husband sitting on one side and an attendant on the other, trying to keep the clothing on the patient and bed. She did not notice me when I came in, but kept up a constant jerking motion of all the voluntary muscles of her body. It was impossible to tell which portion of her body twitched the most. Her tongue protruded from her mouth the most of the time, and she moaned as if in distress. She was a most pitiable object to behold. It was very difficult for her to answer questions, and her speech was so interrupted with the twitching of the muscles of the face and mouth that I had to call on her mother to interpret what she said.

I succeeded in getting the following history: She had been married about a year; was pregnant but did not know how long she had been so, thought it was three or four months. She had been in good health when she was married. But when she was a child she had an attack of chorea for several months.

The jerking and twitching of her muscles continued both day and night except when under the influence of morphia for three or four hours during the night. She had been suffering from her present attack for three weeks, and had been under allopathic treatment all the time. Her tongue was coated and her bowels were constipated. She had no appetite, and took only a small amount of any kind of food. I ordered her room to be kept very quiet and the admittance of plenty of fresh air, also nourishing broths and fresh milk. Gave her zinc val. 3^{x} one two-grain tablet every four hours alternating with nux vom. 2^{x}

every four hours, and at night a single powder of sac. lac. to please her friends, who thought she could not sleep without a powder.

The first night she slept three or four hours, and the next day she was a little better. The second night she slept well without any powders. In the next four days was around the house with only slight twitchings occasionally. Appetite good, and bowels regular.

She is still taking zinc val. one or two doses a day, and nux vom. one or two doses a week. She is feeling quite well, is increasing in strength and is growing fleshy, expecting in a few weeks to become a mother.

DISCUSSION.

F. PARK LEWIS: Enough of the pathology of chorea has been determined to demonstrate that in certain instances at least it may be a reflex, and that a certain proportion of cases are due to eye-strain.

I feel thoroughly assured that our knowledge of chorea (or of any other profound nervous lesion) is not complete until all the conditions upon which it may depend have been investigated. I have seen profound nervous troubles so relieved by correction of heterophoria—troubles of the extrinsic muscles of the eyes—that their histories read like fairy tales.

G. W. WINTERBURN: My criticism of the paper just read is, that it teaches us nothing useful. Here are three cases of disease, which from the symptoms are different; they are all called chorea, and they are all treated by the same remedy, without any indication why that particular remedy was selected. It is certainly not true that all cases of chorea can be cured by the remedy that was given for these, nor by any other one remedy, and unless the paper shows why the remedy was given it certainly is no advantage to anyone. Therefore, I think that such a paper might very well be returned to the writer with the request that he should state explicitly why the same remedy was given in three cases in which the symptoms varied very greatly.

B. G. CLARK: My first case of chorea was a girl twelve years old in which it developed after scarlet fever. Her old school physician battled with the chorea for about six weeks. The symptoms continually were getting worse, and although the mother was quite opposed to the idea, as her father and three brothers were old school physicians, she brought the child to me, with her son, in a sleigh, and each one of them sat on either side of her on her dress to keep her in the sleigh.

After a careful examination I gave sulphur 200, which was continued for about ten days. The child was very much improved.

W. M. BUTLER: If there is one thing that homœopathy can cure it is chorea. Tarentula hispaniola 200th has given me most satisfactory results in cases characterized by muscular incoördination; the patient seems to have no control of his muscles, when he walks he lurches and stumbles.

JOEL D. MADDEN: I have obtained very gratifying results in the treatment of nervous diseases by dilating the anus.

JOHN L. MOFFAT: The majority of the reported cures by homœopathic medication leave us to infer that the relief was prompt or state specifically that it was so. I must confess that in my own experience such beautiful results have been in the minority. While I am satisfied that at times my medicine has cured the patient in quick order, usually the result has been too slow to lay any claim to brilliancy, and generally more than one remedy has been required for the cure as the disease has presented varying phases. I have been treating a boy for the past three or four years who has been suffering from an aggravated and obstinate form of chorea, characterized by facial twitches sniffing and jerking of the head and arms. At one time he would drop whatever was in his hands if his attention was diverted. He is of a marked neurotic temperament, but is gradually and surely recovering—in fact is now almost well. Circumcision was found to be necessary, and was performed; at first there was an aggravation of his nervous condition, and I have never been able directly to attribute any of his cure to the operation. Tarentula hispaniola has been his main remedy, with occasionally zinc, hyoscyamus, belladonna or arsenic.

T. F. ALLEN: According to my observation chorea is a disease of mal-nutrition; that is to say such patients are anæmic or have some constitutional impairment. I study the history of each case carefully, and often feed them up——raw beef sandwiches come well in play. I have found much benefit from quicksilver, which can produce a terrible form of cholera. Until within four or five years ago I had been rather skeptical as to its curative properties, but I have certainly seen three or four aggravated cases benefited by mercurial treatment. I have not given it higher than the 7th or 9th.

ASTHMA, A RESULT OF PLEURITIC EFFUSION.

W. S. GARNSEY, M. D.

GLOVERSVILLE.

February 17th, 1892, about midnight, I was called to see Mrs. T——, a lady about seventy-one years of age, who was suffering from an attack of spasmodic asthma. It was the first attack of the kind she had ever suffered, and I found her much excited and alarmed. I prescribed aconite and arsenicum. In two or three hours she became quiet and the next day seemed as well as usual except a little bronchial cough.

These asthmatic attacks were quite frequent during the next four weeks; the paroxysms when present always appearing about midnight and lasting from two to six hours. A great variety of remedies, both homœopathic and otherwise, were tried to relax the spasms; the most effective being the inhalation of the fumes of a burning mixture composed of belladonna and stramonium leaves with powdered cubebs, nitrate and iodide of potassium. This with other means often failed, and the paroxysms would wear out. During the daytime she was kept on such remedies as seemed indicated.

About two weeks after the beginning of her asthma, one day when her breathing was quiet, I examined her chest and found an accumulation of fluid in the right pleural cavity. This was a surprise to physician as well as patient. I had been her medical advisor for the past ten years, and had never known her to complain of any trouble on her right side. Indeed she declared she had never had a pain on that side. In December two months previous she had been sick a week, the first two days of which she had a slight elevation of temperature, with severe pain in the left chest, particularly over the apex of heart, from which locality it shifted to a small spot on the left arm corresponding with the insertion of the deltoid muscle, but at no time did we have even a suspicion of trouble with the right side.

Immediately on discovery of the effusion, medication was instituted to induce absorption, but after two weeks of trial with no reduction of fluid nor freedom from the attacks of asthma, on March 12th I aspirated, removing sixteen ounces of a clear fluid, but desisting before the cavity was empty for fear of shock. Improvement was marked and immediate; no asthma appearing for two weeks. Appetite and

strength increased, so that she did part of the house work. However, in spite of my best efforts to the contrary the fluid increased, and with it came a return of the asthmatic attacks with general debility, so that on April 13th I again aspirated removing about eighteen ounces. This time the fluid was a dark straw color and contained a little blood, and before withdrawing the needle she complained of pain. General improvement and relief from asthma followed as before, but she was not as strong as after the previous operation.

On May 5th I drew off the fluid the third time, and it was clear like the first. She was able to be around the room the most of the day but gradually failing. During this month she had no violent asthmatic attacks, but suffered with dyspnœa, and at night was frequently obliged to sit up in bed.

June 7th I aspirated her for the last time, drawing twenty ounces of clear fluid. From this time till her death she was confined to her bed, steadily losing strength of body and mind, and the last three days she suffered severe pain in her head and the left side of her abdomen. She died on the twenty-second day of June, a little over four months from the first asthmatic attack.

The points to which I wish to call special attention, are the stealthy onset and unsuspected presence of the pleuritic effusion. Also the causal relation of this fluid to the attacks of asthma as evinced by the prompt relief which followed thoracentesis.

VERIFICATION OF CULEX MUSCA (MOSQUITO).

B. L'B. BAYLIES, M. D.,
BROOKLYN.

C. M. was sallow, lymphatic and anæmic, affected with ascites and anasarca, sick about 2½ years having in November 1889 vomited three quarts of blood, in July 1890 he again vomited blood, the following November a third hæmorrhage occurred, and in February, '91 a fourth, the intervals between the hæmorrhages being successively 8, 4 and 3 months. Ever since the first attack he was unable to perform any manual labor and at intervals has had vertigo immediately while sneezing or blowing the nose, most frequent while going from the house into the open air; also a suffocative dry laryngeal cough and

since the first hæmorrhage the singular sensation as if the lower ribs and right side of the abdomen in the region of the liver and lower chest were removed and cold air was constantly blowing through the cavity; a stiff and tired feeling in the lower limbs; constipation with white fœcal passages; nostrils dry and obstructed by bloody crusts, foul odor of the breath; urine offensive; formication of the hands and feet. Culex musca (mosquito) (provings by 16 persons, compiled and arranged by Dr. J. T. Kent, of Philadelphia,) produces all the symptoms mentioned except the described sensation in the right lower chest and the hæmatemesis, though it has epistaxis and menorrhagia with black clots. My attention was directed to it by the symptoms vertigo while blowing the nose and sneezing.

April 12th. Culex musca 45m. F. one dose.

April 19th. Face less puffy, abdomen softer, less tumid, little or no vertigo. Sensation of cold in cavity of right side of chest much relieved; in 48 hours he lost the tired and stiff feeling of the limbs.

April 25th. Passage of more natural color, less cough, general improvement, some return of vertigo; face less sallow; R. culex m. cm. F., one dose.

May 9th. Able to work some, a little short of breath, itching of the whole body in the day as well as the night, as from mosquito bites; no medicine.

May 26th. Improved, the urine more abundant of light color, no formication of hands and feet. The improvement has since this note continued.

Oct., 1892. No more hæmorrhages, he has worked during the summer and autumn.

Two sisters had at different times painful sensation of fullness and stoppage of the ear, in one of the right the other of the left with impaired hearing, relieved from time to time for a while by snuffing up air, a dose of nat. carb. 25m. F. removed the deafness. The condition, relief by forcible inhalation is not found under natrum carb. and may be an indication for its use in catarrhal deafness.

PROGNOSIS IN ORGANIC HEART DISEASE.

J. MONTFORT SCHLEY, M. D.,
NEW YORK.

Prognosis in organic heart disease certainly presents features of uncertainty with which the careful observer and painstaking clinician are but too familiar. It is here only of a prognosis quoad vitam and of (moderate) comfort in a physical sense that I would speak; of a cure of organic tissue changes in muscle or valves I need hardly speak, but I will say that many trustworthy observers have seen murmurs disappear and some diminution in an abnormally enlarged organ take place along with the local or general symptoms. Anæmic and functional troubles seem to have been eliminated in these cases.

If we compare the prognosis of heart disease with unoperative carcinoma or diabetes mellitus, we readily see what advantage we have in fixing somewhat authoritatively upon a proximate date of fatal termination in the two latter diseases, while in the former we deal with an uncertain *mechanical* problem.

We must admit of the wonderful workings observed during a whole movement of the heart. It is an organ which certainly stands alone in its mechanism throughout the animal kingdom, and we believe, that a closer study and understanding of its intended purposes, would modify many erroneous conceptions of the profession at large and bring about a more exact prognostic judgment.

It may be of service to refresh our memory upon the normal pulsation of the heart. The entire action of the auricles and ventricles during a pulsation is as follows: "The contraction begins in both auricles simultaneously. Thence it runs rapidly forward to the apex of the heart The entire (*both*) ventricle contracts vigorously, its walls harden, its apex protrudes, strikes against the walls of the chest and twists from left to right, the auriculo-ventricular valve shuts back, the first sound is produced and the blood is driven into the aorta and pulmonary artery. These phenomena occupy about one-half the time of an entire pulsation. Then the ventricle is immediately relaxed and a short period of repose ensues. During this period the blood flows in a steady stream from the large veins into the auricle and through the auriculo-ventricular orifice into the ventricle, filling the ventricle by a kind of passive dilatation about $\frac{3}{5}$ or $\frac{4}{5}$ full. Then the auricle contracts with a quick sharp motion, forces the last drop of blood into the ventricle, distend-

ing it to its full capacity, and then the ventricular contraction follows as above described driving the blood into the large arteries. These movements of contraction and relaxation continue to alternate with each other, and form by their recurrence the successive cardiac pulsations." Though this is written in the single, it applies to both auricles and both ventricles.

It is all important that we keep this picture of the heart's movements constantly and understandingly before us, for the thorough appreciation of what may follow any disarrangement of this wonderful law of physics.

In my mind the two *fundamental* laws of the mechanism of the circulation in the healthy heart, are

I. *Synchroneity of action, i. e.*, both auricles act simultaneously, and both ventricles idem.

II. *Equality of effluxes, i. e.* both auricles and both ventricles empty themselves at the proper time and in the usual way. And just as soon as either one or both of these constant healthy conditions is encroached upon the patient's condition becomes alarming or his life is imperiled. Many of us know personally of patients with serious organic heart disease—where mitral regurgitation, for example, has existed for many years—without any marked impairment of the function of the heart, and where the person seemed to suffer no marked inconvenience from his malady, being often unaware even of its existence; here the compensatory power of nature overcomes for a longer or shorter time the injurious effects which the morbid lesions produce, and cause the blood to flow evenly as in health from the right and left ventricle. In these cases there is still: 1. Synchroneity of action. 2. Equality of effluxes, and as long as this continues, the patient's well-being is not interfered with and his life-course may not be shortened thereby.

Let us look a little nearer at such a case. In the healthy heart the left ventricle sends out at each contraction about three ounces of blood through the aortic opening. Let us, however, suppose that by reason of imperfect action of the mitral valves, a small quantity (say one drachm) finds its way, in consequence of the ventricular contraction, into the left auricle, meeting the blood which is already flowing into that chamber; the amount of blood which is, therefore, present in the auricle at the close of the ventricular contraction must be equal to 3 ʒ plus the drachm above mentioned. Ventricular dilatation now takes place, admitting into that chamber the whole of the contents of the auricle, by reason of the natural dilatability within certain limits of

the walls of the ventricle. As the ventricle must now contract upon a larger mass of blood, its functional activity must be increased in order that it may completely empty itself, and by this contraction the normal amount (3 ʒ) is expelled through the aorta, and the drachm regurgitated, as in the previous beat of the heart, into the auricular cavity; this process is continually repeated in exactly similar manner, beat by beat, with the ultimate result of the walls of the ventricle becoming hypertrophied to an amount corresponding to the increased functional activity, and thus the individual may live for years, exhibiting in his heart a marked mitral regurgitant murmur, but in his daily life little or no functional disturbance of its action. The compensation is complete, and the diseased heart acts in all respects as a healthy one. It must be borne in mind that the left auricle becomes also strengthened by the hypertrophy of its walls. As it has to contract each time after emptying its contents upon 3 ʒ and a drachm of blood in place of the normal 3 ʒ, the increased functional energy necessitated develops the increased muscularity of its parietes.

Let us suppose in another case that the auricle retains for a time half an ounce, so that it is dilated to hold 4 ʒ, three ounces from the right heart, half an ounce from the left heart, and half an ounce retained. The auricle now gradually hypertrophies and drives into the ventricle three and three-quarters of an ounce, instead of three and a half ounces; the ventricle is therefore dilated to hold three and three-quarters ounces, and it sends out as before three ounces into the aorta, half an ounce into the auricle, and retains quarter of an ounce permanently. Now suppose again that the auricle further weakens and retains for a time three-quarters of an ounce instead of half an ounce. It will now contain three ounces from the right heart, half an ounce regurgitated from the left ventricle, and three-quarters of an ounce retained, amounting altogether to four and a quarter ounces; it is, therefore, now dilated by four and a quarter ounces. But let us further suppose that it again gradually hypertrophies, so as to expel 4 ʒ into the ventricle. The latter is, therefore, dilated to hold 4 ʒ plus a quarter of an ounce which it permanently retains.

Two conclusions may be drawn from the above:

However much the auricle is dilated beyond its normal size, that as soon as it hypertrophies to a sufficient extent so as to drive almost the whole of its contents into the ventricle, leaving a small quantity behind (in the above case it is a quarter of an ounce), the ventricle is dilated to exactly the same amount as the auricle; in fact, the auricle, by its hypertrophy, is able to send back into the ventricle almost the

whole amount of blood, which, through the weakening of its wall, it had subtracted for a time from the ventricular contents.

The anatomical conditions, which, if the above reasoning is true, we should expect to find are:

a. Great dilatation and corresponding hypertrophy of the left auricle, both of which are permanent.

b. Dilatation of the left ventricle to an almost corresponding extent, and also hypertrophy, both of which are permanent.

c. Chronic congestion of the lungs.

d. Hypertrophy of the right ventricle, and, from this point on we simply have to follow the circulation backwards to obtain an enlarged liver, a congested mucous membrane of the stomach, enlarged spleen, passive congestion of the kidney with its accompanying albuminuria, anasarca and ascites, and finally a painful and long-coming death.

I reiterate the statement here again that as long as a thorough compensation exists, such a termination need not be looked for.

These cases, with hypertrophy and marked murmurs, are rather easy of recognition, but there are others *without murmurs* and with little or no enlargement—often escaping attention—ending sometimes suddenly in a fatal manner, which are very frequently unrecognized or unrecognizable by our physical tests. It is more especially to these conditions that I would draw your attention for a few moments. These latter cases are more apt to occur after the age of forty-five, and unlike those conditions which have thus far received our attention, are not provided for in nature's preservative methods. No compensatory hypertrophy stands ready to lift the load or to make it more easily and safely borne. Though much advance has been and is being made yearly to a more thorough understanding of heart diseases and their accompanying sounds and symptoms, yet there remains much to be learned, and also much to be unlearned for lack of its correctness.

One well-known author says he has never heard a diastolic bruit emanating from the mitral valve when stenosed—another denies the existence of a presystolic murmur over the mitral orifice. We admit of great variations in these two bruits, of their occasional disappearance and reappearance, of their occasional existence for a short period and their complete absence afterwards owing to the great distension of the auricle and its muscular debility.

Much has been written on cardiac signs which are hypothetical. It seems as if one (or more) distinguished teacher had evidently written of them in his study as it seemed to him that they should be, without comparing the signs of disease in the living with pathological evi-

dences after death. Some of these views, received with the stamp of authority of a great name, were added to by succeeding writers, resulting in a mass of misleading literature, difficult at times to unlearn. The general disregard of writers on chest diseases of the laws of acoustics suggests some ignorance of them. Acoustics, however, could hardly be considered an applied science until within these few years, since the introduction of the telephone. But the absurdity of writing on a scientific subject without applying to it the laws pertaining to that science should deter us from discarding a mass of mystifying hypotheses.

Yet simple facts were observed and recorded and experiments were made which fix certain points beyond the domain of cavil, as was done in regard to the second sound of the heart being caused by the resiliency of the aorta forcing the blood back against the semilunar valves and closing them with a shock. This was determined by experiment as well as by observation; as when the valves were hooked up or destroyed the sound was absent (Balfour and Hope), when the valve was merely injured, the second sound was altered in character or was supplanted by a diastolic bruit. This also enabled us to understand the philosophy of the rhythm of the heart, and of the intervals of silence. The systole of the heart having taken place, accompanied and characterized by the first sound, the heart rests, relaxes and passively fills slowly with blood. If there were no closure of aortic valves there would be but one prolonged interval of silence, until the heart should again commence to contract. But the second sound accompanying the forcible closure of the aortic valves divides the interval of silence into two of unequal times, so that we have established beyond controversy the facts of the first or short interval of silence, the second or short sound and the long interval of silence. The first sound alone remains the subject of changing opinions, of doubt and false diagnoses.

You will pardon me if I dwell at some length on these two most important points, as for a matter of fact, the sounds themselves, their intervals of appearance, etc., their approachment or wider separation are commencing to be found all important for the diagnosis of these doubtful and obscure cases.

The first sound occurs during the systole of the heart. It must then be caused by the contraction of the heart, as one of the factors. But the sound will not take place even if the heart contracts unless the heart is filled with blood. It has been demonstrated that the heart contracting while empty will be unaccompanied with sound. Hence it is inferable that were the heart a closed cavity and were full of blood, the con-

traction would not cause the first sound, nor anything like it. The blood must be forced out through an orifice to cause any sound at all like the first sound.

And with all these conditions perfect and acting correctly, the sound caused will not be the natural first sound. There must be a mitral valve, thin and vibratory, held in its place by the tendinous cords, and then only with all the other conditions acting perfectly and in harmony, will we have the first sound harmonious and natural.

The conditions for the production of the first sound are a perfect heart contracting upon and forcing out blood from its cavity into the aorta prepared for its active reception. The perfect heart must have all its interior appliances such as the mitral valve, chordæ tendineæ, muscular walls (muscle throughout), columnæ carnæ, musculi papillares, nerve supply and pericardial covering in the normal state. The contractions also must be regular and not spasmodic, and the blood must be of its proper consistency, or we will not have the harmonious and rhythmical first sound.

It goes without saying that a sound-producing instrument of such delicate construction, and controlled by a sensitive nervous system often under the influence of external causes, must frequently be out of order, so as to be noted by the variations of the systolic sound, without serious structural change invalidating its mechanical efficiencies as a pump.

There are structural changes in the heart (muscular tissue) itself which may weaken its muscular contraction, but still its normal function will remain, but it will be accompanied by alterations of the first sound characterizing the gravity of the lesion without changing the rhythm.

But where there is obstruction to the flow of blood into the aorta, causing hypertrophy, or where there is incapacity of the aortic valve or the mitral valve, then the rhythm will be altered or lost, and the first sound eventually changed in character, and the proper relation of time of the first sound and first interval of silence, the second sound and the second interval of silence, will be altered, and is of far graver import to the life of the individual than murmurs, although they also have their value when rightly diagnosed.

But this is wherein the value of a scientific and consequently correct diagnosis has its highest appreciation, to distinguish the functional and extra cardiac lesions from those invalidating the valves or weakening the heart's action. In one, the heart may remain through life capable of successfully performing its office; the other indicates the begin-

ning of farther structural changes, ending either in sudden death or prolonged and agonizing suffering.

Thus we see that two great divisions in cardiac (organic) diseases may be safely made, the one taking up mainly endocardial inflammation with crippling of the valves, chordæ tendineæ, etc., with their respective and necessary hypertrophies and dilatations; the other, where a faulty nerve action or supply, or muscular changes occur.

The first division we meet at all times of life, the second one most frequently, if not alone, after the age of forty-five. A mitral insufficiency at the age of seventy is surely a more alarming malady than a mitral incompetency at twenty.

Only yesterday a young lady æt. 17 was brought into my office by her physician from Detroit, Mich., for a physical diagnosis. Her complaints were headache, "fainting turns" and occasional neuralgic pain in the cardiac region. Patient on examination was found to be anæmic, had a poorly developed thorax, but no lung disease. At the apices and bases of both lungs pleuritic adhesions were detected. Mitral insufficiency with slight hypertroply completed all that was found to be abnormal. Patient was well nourished, digestion perfect, spleen not enlarged and so on. Urine had not been examined. She could walk or run up-stairs without much oppression in her breathing and was an expert lawn-tennis player. Prognosis was favorable, and it seemed to me that her chances of longevity were better than other patients visiting me that morning who had no cardiac maladies. I have seen such young persons go through typhoid fever and pneumonia repeatedly, and on a careful re-examination after recovery have not been able to detect any aggravation of their old chronic disease. In this young girl's case, attention to a few things will certainly keep her trouble from growing any worse. A very simple and nutritious diet—super-alimentation, flannel or silk underwear all the year around, moderate exercise daily, lung gymnastics and the indicated homœopathic remedy for the neuralgic thoracic pains are all that are necessary. Compensation was complete in this case.

To give such patients digitalis, adonis, apocynum or strophanthus continuously as is so often done in similar cases seem to me harmful and unwarrantable. A time often comes in just such cases, in twenty or thirty years from this writing, when the materia medica may bring relief. In the child, in the young girl budding into womanhood, in the lad growing into manhood, medicines cannot restore a sclerosed or contracted valve flap, and if we would only pay our utmost attention to

the patient's general nutrition and a steadying, fortifying of their nervous system, their hearts will not discommode them.

I have had opportunity upon opportunity to observe for many years such cases in the young as I have just cited. One of the whole number has died from organic cardiac disease. I cannot bring to my memory a single case of a patient with dropsy (anasarca and ascites) under twenty-two years of age—where this condition was alone due to faulty valve action. Some of these young people were not aware of their deranged endocardium. An aggravation of such a chronic condition is brought about by over exertion of whatsoever nature, acute febrile onsets, chronic but more especially acute inflammatory rheumatism and advancing years. All other factors play an undetermined role.

What then are we to say directly to such a patient? Is it wise and judicious to lay much stress upon a condition which may remain in statu quo for an indefinite length of time? Is it advisable to draw the attention of a person just entering the anticipations of a young life to the ownership of a dreaded and mysterious malady? Are we not justified in painting the future for such patients in brighter colors than we are in the habit of doing?

I hold to the fact that we are amply fortified in all our endeavors to keep from cardiac patients all knowledge of their disease—unless it be in exceptional cases. A man or a woman is never the better for knowing that he or she is suffering from cardiac disease. If a patient will not follow certain directions as to his daily life it may be forced upon his medical attendant to lay the bare facts before him. His relations should always be acquainted with his condition—no matter what you tell the patient directly—such patients' lives then up to a certain age are in a measure in their own hands,—their daily comfort depends upon the strict carrying out of certain regulations.

Let us compare a case of an old gentleman seventy-three years of age, with this young girl. In 1879 he was told by two of London's best known authorities to return home and prepare for another æthereal atmosphere. He should give up his business, etc., etc., etc. He did return home, but he worked all the harder and went on increasing his business. To-day—more than twelve years after this prophecy—he is commencing to show signs of advancing myocarditis. In 1879 he was not aware of any cardiac lesion. On his return here his malady was substantiated. Now we find marked atheroma, hypertrophy of left and right ventricle—mitral and aortic insufficiency, and irregular, and unsustained pulse. The kidneys show croupous nephritis. On auscultation we obtain a systolic bruit over apex and diastolic over the

aorta, both of a loud rasping character. Slight œdema pedum is noticeable. This patient complains of headache, dizziness, loss of memory, sleeplessness, great weakness and lassitude, and oppression over cardiac region on exertion. Here is a man whose heart muscle is insufficiently nourished and where a hearty meal or any violent effort will stop it in systole. Here is a patient then whose tenure of life is surely uncertain. Can we talk to him even of next year as confidently as we can to our first patient of the next twenty years?

In coming to a final determination about a patient's future, we should never lose sight of his pedigree. There seems no doubt existing that a history of family cardiac lesions must enter largely into our prognosis. If the patient before us has lost one or more uncles or aunts from organic heart disease—we must not lose sight of this.

Again I would earnestly draw your attention to the subject of fatty degeneration in this relation. It does not exist as frequently as it is supposed and we have it on the best authority that after its recognition he has known no patient to live longer than two years. The diagnosis of fatty heart is not always easy or satisfactory. Its prognosis is more certain and accurate when diagnosed than any other heart malady. In formulating a prognosis we have always in serious cases one test to fall back upon, *i. e.*, the response shown after the administration of cardiac remedies. If one or more fail us in our need, the patient's end is nigh at hand.

To summarize let us keep the following points before us ere we render a final decision in all organic cardiac lesions.

I. A correct diagnosis.

II. The age of our subject.

III. The family history pertaining to arterial or heart disease.

IV. The presence or absence of synchroneity of action and equality of effluxes.

V. Thorough compensation, and by this I mean, whether the compensation which has been established is adequate and efficient, and how far it promises to be durable. Compensation is efficient when there are no symptoms of embarrassment of the circulation, and when the heart responds to all ordinary calls upon it without undue shortness of breath or respiratory distress. The effects of exertion are an important criterion, due allowance being made for the greater liability to breathlessness which is natural to some individuals, or is produced by bodily conformation or results from a sedentary mode of life.

VI. The complications of nephritis, hydrothorax, or obstructive lung troubles.

VII. The structural lesions mostly met with: hypertrophy, dilatation, fatty degeneration—the rare ones: cancer, syphilitic gumma, abscess, aneurism and localized or diffuse fibrotic induration. To differentiate these.

VIII. The heart may be worn out by an unhealthy mode of life or by protracted emotional strain, or the patient's tissues generally may lose their nutritional value early. Facts of this kind are not revealed by a physical diagnosis; some of them may be known to the family medical attendant, but otherwise they are ascertained only by persevering and careful inquiry. It is obvious, then, that many other considerations enter into a true and thorough diagnosis and prognosis besides purely anatomical conditions.

IX. A frequent, short and unsustained pulse and heart beat, and long-continued great frequency of the pulse are unfavorable signs.

X. A greatly dilated heart which is capable of giving a recognizable apex beat and fair impulse of right or left ventricle or both, is more to be trusted than one which has apparently undergone less change, but the movement of which can scarcely be felt at all. It is always better, again, that the sounds should be strong than weak, *spaced* than *approximated;* and it is important that the second sound of both ventricles should be well marked.

XI. Finally, we would state, that prognosis in chronic (organic) structural diseases of the heart, is not merely a well-instructed conjecture as to the ultimate issue, it is a deliberate judgment as to the processes and tendencies of the disease and as to the constitutional soundness and strength of the patient; the foresight which relates to the dangers which attend all cardiac attacks, to the course which it will run, and to the influences and contingencies which make for or against the sufferer.

BIBLIOGRAPHY—Davis', Cammans', Leaming's, Broadbent's, Balfour's and Hopes' writings.

REPORT

OF THE

BUREAU OF PÆDOLOGY.

"The Leucorrhœa of Children," - - - GEORGIA A. CASSIDY.
"Stomatitis," - - - - - - J. OSCOE CHASE.

THE LEUCORRHŒA OF CHILDREN, ITS DANGERS AND NEGLECT.

GEORGIA A. CASSIDY, M. D.,
BROOKLYN.

At first thought, one may think this condition of affairs impossible, or at least an anomaly, but a little further investigation of the patients that come in our way will show the importance of the matter.

Leucorrhœa being a form of catarrh, there is no real reason why it should not arise in one mucous membrane as another, all the external passages being lined with this most delicate membrane, makes them so much the more liable to irritation, either acute or chronic. This irritation may be caused by foreign substances, outside of conditions of hyperæmia and congestion, resulting usually in a diseased condition.

It is true that it is more often found in children of a strumous diathesis, having poor nutritive and assimilative powers, and whose mucous membranes suffer in all directions, yet not always, for I have come across many children well cared for and nourished in the most comfortable manner, who are afflicted in this way.

Leucorrhœa even in a grown person is well known to be a great drain upon the nervous system of which the network and supply to the parts is so intricate and full.

The leucorrhœa if continued for any length of time quickly tells upon the general health. The parts are thus kept in a high state of

irritation and made hypersensitive in every way. Hysteria often developes from this cause in very young children, and is usually attributed to ill-temper. The poor child hardly knows what is the matter, only that she feels badly all over and more or less despondent and unhappy. This occurs even in young children. Then follows the excoriation of the parts, the only thing usually done to relieve it being more or less frequent washings with soap and water. This, however, usually aggravates the condition. The rubbing and friction usually irritate the parts the more, and the last condition of the child is far worse than the first. Indeed, in these cases, the less washing and rubbing there is, the better; the skin and membrane covering the parts being light and delicate at best. Water if used at all should be warm and one-third glycerine and listerine, with a few drops of carbolic. The parts should be gently patted until dry, and this done as seldom as compatible with cleanliness. Better still, is to use a small syringe by which means the water simply flows over the parts, drying with soft cloths. The syringe also cleanses the vagina more thoroughly than any possible cloth can. It is true that in many of these cases, the discharge seems to come more from just within the labia and anterior to the hymen, yet far more in my experience have a deeper origin, and the vagina will be found congested and hot to touch. The discharge is often at first only slightly colored but profuse, yet may take on later a far more serious appearance, being thick and greenish as in acute vaginitis or vaginismus, and there is much of the latter.

In these cases should the discharge be carried to any other mucous membrane, as the eyes, it will cause a most acute and virulent condition, as I have seen repeatedly, resulting in a most aggravated form of purulent ophthalmia, with imminent danger to the sight.

It is true you find these bad cases perhaps more often among the tenement house population than in those of better circumstances, but I have seen cases among the most respectable people, for there is not the careful oversight of children in good homes that there should be, one evil-minded or disposed child being quite enough to pervert many others, as I have found over and over again. Mothers are shocked when you tell them of the too evident evil habits of their children, but the ocular demonstration is easily made.

These bad cases of ophthalmia develope more often in children who physically and mentally lack tone, and have an inherent tendency to catarrhal discharges. Such children are also often subject to enuresis, and are punished and treated for the latter when it is only a secondary result. Because the whole vaginal outlet and urethra are in such a

state of irritation many times from some form of leucorrhœal discharge, the child dreads to pass its water, hence it is held to the extreme limit of time, with the result of wetting bed or clothing.

This constant irritation and tenderness of parts leads to handling of same, and then the fingers are somehow carried to eyes with aforesaid result. To guard against this condition children should be kept perfectly clean and washed every day; particularly in and around vaginal outlet all the little cheesy accumulations, often found in the best of children, being carefully removed, and any irritated surface being noticed on the spot instead of slighting or overlooking these parts, as is usually the custom, through a feeling of false modesty. Neither should bathing be left to children themselves, until pretty well grown, and then instructed.

Catarrh of these parts may result from cold or chills from sitting on damp ground or else there may be some local irritation, as of tight drawers, or from latter not being well cut and fitted. Also with some children the urine is of such an acrid, irritating character that their drawers require changing every day or oftener. Better in these cases to cleanse the child every time after passing urine with a little ammonia or borax in water and glycerine, and give the indicated remedy, or regulate the diet to correct condition of urine. You will notice this acrid urine in children who are fed too much meat or not sufficient fruit and vegetables. If not seen to, this will eventually result in a more serious kidney trouble from excess of uric acid and water. In a little child the mucous membrane and skin in and around the vaginal outlet are as sensitive and tender as in the eye, and require just as careful attention and handling.

The exposed situation in most schools of the closets render children who are poorly fed and nourished at best more liable to cold attacking vaginal passages from sitting in draft, leucorrhœa soon developing. A number of cases have come to dispensary from institutions near us with purulent ophthalmia, which has spread from child to child from carelessness and overcrowding or by direct contagion, the cases usually exhibiting leucorrhœa also. The treatment of these cases, when living in crowded tenements, can only, of course, be carried out properly in a hospital ward, and even there great care is needed. Among the better classes of children a nurse should be obtained who can and will carry out the physician's directions implicitly and give strictest attention to all details of treatment upon which so much depends. In strumous, unhealthy children, already reduced by anæmia, there is sometimes a transition of the disease and acute inflammation to the

membrane of the brain, resulting in destructive inflammation or a hydrocephaloid condition. In these cases not a too hopeful prognosis should be held out, and an *if* always figuring largely.

The eyes and brain are so intimately connected and the disease, purulent ophthalmia, is such an exhausting one, from the great quantity of pus and serous matter thrown off, always causing more or less nervous depression, that brain disease as a result, even after the local trouble seems cured, is not at all uncommon. This should be guarded against most carefully as a change often sets in suddenly, only perhaps a rise of temperature or a fall below normal being noticed. But this in itself should be a warning to renewed efforts to keep up the strength of a child under the great drain of system that has been going on.

If the few facts I have given will stimulate anyone to look further for a first cause, when these sadly frequent cases of purulent ophthalmia come to them, and lead to a thorough investigation and recognition of the catarrhal condition of the vagina so often found in my experience, they have not been in vain.

For with me it goes without saying, that when a bad case of ulceration of the cornea with purulent ophthalmia occurs, vaginitis and leucorrhœa will be found with its depressing and weakening result a factor in the case.

DISCUSSION.

GEORGE WILLIAM WINTERBURN: This is a subject of more importance than is ordinarily attributed to it. There are more of these cases than ever come to the doctor's attention. Parents do not consider them of any importance because the discharge is usually very slight. There are a great many children eighteen months old and two years old that have a vaginal catarrh; they are difficult, of course, to treat, not only because the mother does not understand the importance of it, but because she feels a certain delicacy about it,—a sort of family shame, and tries to cover it up.

STOMATITIS.

J. OSCOE CHASE, M. D.,

NEW YORK.

In diseases of children it is difficult to find a subject upon which so much confusion has existed. Hippocrates and Galen and their followers first used the term aphthæ, and by degrees every trouble that took place in the mouth was called aphthous until some authors drew their lines of subdivision so finely that they made a great many varieties, sixteen according to Sagar. The historical development has been very slow, nothing definite having been given previous to the last quarter of a century. Our present text books, especially those on practice, in nearly all instances, if examined, will be found weak upon that part pertaining to diseases of the mouth.

The following sub-divisions are the most generally recognized:

I. Stomatitis catarrhalis. (Erythematous stomatitis.
II. " aphthosa. (Follicular stomatitis [Billard].
III. " ulcerosa. (Stomacace.
IV. " gangrenosa. (Noma or Cancrum oris.
V. " parasitica. (Thrush.

Catarrhal stomatitis denotes a moderate inflammation of the buccal mucous membrane, usually acute in its course, unattended with danger and does not proceed to ulceration. The disease may be primary or secondary, and occurs most commonly during dentition. The course depends upon the cause and treatment adopted, rarely lasting longer than a week.

Aphthous stomatitis is considered by some to be of rare occurrence but it is certainly more frequent than uncomplicated catarrhal stomatitis, occurring generally between six and fifteen months. The anatomical lesions are hyperæmia of the mucous membrane of the mouth and the formation of aphthæ or small superficial yellowish white ulcers. It may be epidemic but is not contagious. The discrete form lasts from eight to ten days; while the confluent variety may run three months or more. The patches are usually discrete and make their appearance first on the inside of the lower lip and cheek where the membrane is reflected on the gums, and upon the edge of the tongue; subsequently they may extend to the cheeks, gums, soft palate and

even the tonsils. They are oval in form, appearing slightly excavated, and their size varies from that of a pin's head to that of a pea.

Thrush bears the closest superficial resemblance to aphtha, but its peculiar curdy-like exudation is not found in the latter disease, and under the microscope, the absence of the cryptogam, oïdium albicans makes the diagnosis positive. Confluent aphtha may be mistaken for ulcerative or ulcero-membranous stomatitis, especially when the emanations from the mouth exhale a disagreeable or fetid odor (Cohen).

Ulcerative Stomatitis, the putrid sore mouth, "is a destructive ulceration of the border of the gums, producing extensive swelling of the entire mouth and a cadaveric breath." The morbid process usually begins at the margin of the gums of the lower jaw, creeps gradually backwards and attacks somewhat later those portions of the mucous membrane of the lips, cheeks and tongue which are in direct contact with the affected gums. Occurrence—never before dentition; most frequently from the third to eighth year of life, also during second dentition. Duration—about one week, the bad cases, however, running three or four weeks. The disease is seldom seen in private practice, but is frequent in the poverty tenement districts, and at times epidemic in our hospitals and asylums.

At the N. Y. Ophthalmic Hospital we occasionally see the milder forms of ulcerative stomatitis. At the N. Y. Homœopathic College Dispensary the more severe forms are observed, while at the Five Points House of Industry during an epidemic of measles in August and September of this year, more than one-half of the cases were attacked with a bad form of ulcerative stomatitis. Time will not permit me to go into details, but as the last cases were of a uniform type I will briefly describe them.

A few days after the eruption of measles the gums became tumefied, soft, purplish and would bleed easily upon touch; the breath was offensive and a rapid degeneration of the gums followed, the edges receding, leaving the teeth exposed nearly to the alveolar process, a grayish deposit formed which would slough away in large pieces in some instances. As the majority of these children enter the institution in a badly nourished condition having scorbutic, syphilitic and scrofulous taints, we found that merc. sol. 6^{x} was most generally indicated, the cases being cured in from one to two weeks. There were a few exceptions, however,—one boy developed measles August 22, four days later stomatitis set in, the ulcers were deep, involving not only the gums but the cheeks and edges of the tongue, the discharge from the mouth was offensive and cadaverous. Dr. J.

Arschagouni, the resident physician, applied dilute nitric acid locally and gave nit. ac. 30^{x} internally. I last saw the case two weeks later, September 10, when it was discharged cured. Another case, Dr. Arschagouni applied a solution of permanganate of potash, on a cotton applicator, to the affected parts, daily; which immediately stopped the proliferation of bacteria and prevented further sloughing, the ulcers healing quickly.

There were two fatal cases—1st, Maude Church, aged 2 years, had measles August 4, accompanying acute miliary tuberculosis; destructive ulceration of the lower jaw followed with a gangrenous odor and exudation. Died six days later. 2nd. Grace Henry aged 2 years and 7 months. Measles August 13, with general tuberculosis; two days before her death, which occurred August 25, a membranous exudation filled the fauces, rhino-pharynx and nares, with a foul discharge and excoriation about the nose and mouth.

Treatment.—The remedies most useful in stomatitis are: For the simple or catarrhal form, merc. sol.; the aphthous variety, borax; while in the ulcerative form, sulph. ac., nit. ac., merc. sol., merc. cor., hydrastis can. and staphysagria, are of great value.

Gangrenous stomatitis being of such rare occurrence and malignant in nature is never confounded with the simpler forms. It may follow the graver forms of the ulcerative variety, but is easily distinguished by the tumefaction and formation of an ulcer in the cheek, with the offensive gangrenous odor which is always present.

Parasitic Stomatitis (Thrush) according to Vogel, is neither connected with inflammation nor with the formation of ulcers, but depends upon the abundant development of a microscopic fungus, the oïdium albicans (Robin) which combines with the epithelium into thick white membranes, and covers a great portion of the mouth. Henoch is of the same opinion and shows that when thrush fungus was discovered in 1842 by Berg of Sweden, all previous explanations of the disease as due to inflammatory exudation fell to the ground.

It is a disease of infancy, most frequent during the first two weeks, and from that up to the third month, extending even to eighteen months. After two years of age, and in adults, it is cachectic and observed at the close of some exhausting or fatal disease. It may be contagious. *Causes:* 1. Excessive acidity in the mouth. 2. Transportation from one child to another, by the nurse or feeding bottle, especially in institutions. 3. The fermentation of substances from the suckling bags, the poor milk from badly cleansed bottles, etc.

In short, "the acidity of the fluids and exuberance of epithelium are the requisites for its production—whatever be the cause."

The following case illustrates the severe form of this disease. Lizzie Kemp, aged months, was brought to the Homœ. Coll. Disp. Aug. 17, '92, in a prostrated condition, coming under the service of my colleague, Dr. St. John. Four days later, upon seeing the case, the face was emaciated, the eyes sunken, having a dry, glazed, leathery-like appearance, not having been covered by the eyelids for several days. The entire mouth was filed with thrush fungus, with the exception of the hard palate which was dry and parched. The abdomen had that sunken "boat-shaped" appearance described under intestinal tuberculosis, the muscles were soft, relaxed, and the intestines had that doughy feeling, hard to describe, something like unleavened bread or very soft putty. The stools were very frequent, thin, watery, running away without exertion, changeable. Anus and nates excoriated.

From the start the case was hopeless, the patient gradually sank and died within two weeks.

It is a question in my mind if the cause of this trouble was not due to the invasion of the intestinal tract with aphthous fungi, rather than to tuberculosis; as there was no hectic fever, the temperature at first being about normal but later fell below that point.

Treatment: The uncomplicated or simple forms yield to treatment very readily. In fact, if cleanliness and hygienic surroundings are observed, the cases will get well in a few days. This is facilitated by the careful removal of the patches every few hours with a moistened soft rag. The frequent application of dilute alcohol is excellent.

As this cryptogam can only exist in a soil that is highly acid in reaction, I think we are justified in using a weak alkaline solution, say borax and glycerine locally to neutralize the acidity and destroy the fungi; also during the meantime give our indicated remedy to correct the dyscrasia.

Æthusa, borax and sulph. ac. are useful, while the mercurials are seldom indicated.

REPORT

OF THE

BUREAU OF GYNÆCOLOGY.

"A Case, discriminating Malposition of the Kidney from Pelvic Growths." - - - - - A. LENORA WHITE,
"The Responsibility of the Physician in the Treatment of Obscure Pelvic Disorders in Women," - - - B. F. BETTS,
"Drainage after Laparotomy," - - - HOMER I. OSTROM,
"The Rectal Mucous Membrane as a Means of Preventing Infection in Operations about the Anus," - WILLIAM B. VAN LENNEP,
"Pudendal Hæmatoma," - - - - F. W. ADRIANCE.

A CASE—DISCRIMINATING MALPOSITION OF KIDNEY FROM PELVIC GROWTHS.

A. LENORA WHITE, M. D.,

NEW YORK.

It may seem strange that a correct diagnosis of tumors of the pelvis, which manifest themselves to both touch and sight, should so often prove puzzling, difficult and impossible. Yet ancient as well as modern authorities corroborate this fact, and as far back as I have been able to obtain any reports and have followed down the decades in medical literature, I find that displaced, movable or immovable, kidneys have been mistaken for tumors, especially those of uterine or ovarian origin, and *vice versa*.

The normal position of the kidneys is in the hollows on either side of the spine, extending from the eleventh rib to the crest of the ilium; that is, a space corresponding to the two last dorsal, and the two upper lumbar vertebræ. The right being a little lower than the left, they lie behind the peritoneum, from which they are separated by a layer of cellular membrane that usually contains in its meshes a quantity of

fat. Their mobility is limited normally by this membrane, and yet there is no organ in the body, according to Dr. Newman, that is subject to so great a variation in position as the kidney; the usual deviation being downward, and oftentimes into the pelvis. Hence the frequency with which they have been confounded with pelvic growths. Among the mistakes of this nature, the most repeated has been to consider the displaced kidney an ovarian tumor.

Such a case came under my observation this winter, and I will briefly relate the unique complications. Mrs. J——, a widow, thirty years old, by occupation a scrub-woman and house cleaner, came into the clinic complaining of painful menstruation. She was the mother of two living children, and had had three miscarriages, each occuring about the fourth month. The children were robust, though all the labors were severe and protracted. She gave specific history, but the parental record, as far as known, was negative, and curiously, moreover, she had three sisters with fibroids of the uterus. Her menstruation was established at the age of twelve, and was then regular and profuse though painful, the pain occuring on the second and fourth days. After the birth of her first child the menses were painless, though still profuse. Two years previous to coming to our dispensary she had had an operation for a laceration of the cervix. Ever since the dysmenorrhœa returned and had been so severe she was obliged to remain in bed during three out of the six days of her period. At the time of this operation the surgeon told her that she had a large tumor in the pelvis which ought to be removed, and gave her little hope of regaining her health until this was done. Being afraid of so dangerous a remedy, she did not return to his clinic. She suffered intensely at times from the spasmodic pains of a sharp, shooting nature through the abdomen, but mostly in the left iliac region and down the anterior crural nerve. There was also a constant profuse yellow leucorrhœa, constipation, irritability of bladder, pelvic tenesmus; headache and backache were occasional symptoms.

Digital examination showed the uterus large and anteverted. On the left there was slight thickening and a sensitive hypertrophied ovary, also a small tumor about the size of a hen's egg could be distinctly mapped out, which was freely movable. On the right, situated just off the median line of the vertebræ, and below the pelvic brim, was a mass as large as an orange, which was fixed, resistant and non-sensitive. The sound demonstrated a stenosis of the cervical canal, not due to the version, but evidently the result of contraction after the trachelorrhaphy. From the foregoing I diagnosed morbid growths

in the pelvis, presumably of the right ovary and left broad ligament. I strongly advised treatment with galvanism before resorting to surgical interference. After a few weeks, according to the fashion of dispensary patients, she stopped coming, and only presented herself irregularly at the clinic during the next two years. In all this time her menses were very irregular, varying anywhere from every three weeks to three months.

In August, 1891, she came to my office suffering very much with pains in the left ovarian region. Her menses were delayed six days. I treated her twice a week and at the end of two weeks, when I left the city for a month's vacation, the treatments were continued under another doctor. The patient was miserable, and nothing seemed to relieve her, no matter how carefully selected the remedy.

When I examined her on my return I felt sure she was pregnant. She acknowledged the possibility, but insisted that she had not had a symptom like any former conceptions. No nausea, in fact none of those subjective symptoms, that had previously been so pronounced with her. It was difficult to differentiate the size and position of the uterus, on account of the proximity of the tumor, and the tremendous amount of adipose. I felt very much puzzled over the case. If it was pregnancy why had she not miscarried under the influence of the electricity, which had been unremittingly used during these six weeks? Then, too, the condition of the cervix, ovaries and tubes would seem to preclude the possibility of conception. I asked my preceptor in gynæcology to see the case. He pronounced it pregnancy obscurely complicated, but reserved his diagnosis in regard to the tumors. I kept the woman under careful observation for a month, during which time she grew steadily worse, the pains became general throughout the pelvis, and it was impossible for her to walk, or touch her left foot to the floor, without agony. In the meantime she was seen by other physicians, who decided she was suffering from a tumor in the pelvis, with localized peritonitis. All the diagnoses were handicapped by the superabundance of adipose, and were, therefore, more or less vague.

As the patient's sufferings increased, she implored us to do something, she cared not at what risk, to relieve her. And as she had some temperature it was decided—the patient first clearly understanding all possible dangers—to make an exploration. If the tumors were removable we meant to operate, if they were not, we could satisfy ourselves as to the exact condition and direct our remedies for her relief more intelligently.

Accordingly on the 26th of November the patient was etherized, and

the abdomen opened. The uterus was gravid, extending to the umbilicus. Salpingitis existed on both sides. There was a mass of adhesions on the left, fixing the left ovary and the smaller tumor on that side. These bands were broken up, and the ovary brought forward for inspection. It was found to be hypertrophied only, and left in the pelvis. The small mass was nearer the uterus, but was not disturbed.

The right ovary was smaller, and the tumor on that side seemed to be in the broad ligament but did not encroach upon the pregnant uterus sufficiently to warrant its removal. Though in all probability it would prove an impediment to labor at term and might then demand operative interference, it was thought best to run the latter risk than to remove it in the present condition of the patient. The exact situation was not determined on account of the desire not to produce miscarriage by too much manipulation. The abdomen was not flushed, the wound was closed with silk worm gut sutures, plain dressing was applied, and the patient put to bed in a good condition. Opiates were used to prevent vomiting and abortion. She made a rapid recovery, and said she had not had a pain since the operation. I had not seen her in several weeks, when I was called up one night about two o'clock and found my patient in hard labor. She confessed it was induced. The pains were good, but there was no dilatation, and the descent was interrupted by the tumor, which was pushed downward with each pain, but resumed its original position as soon as they were off. The mobility of the mass was slight, not more than two or three inches, yet it proved a great hinderance to delivery, and very puzzling to the doctor and myself. I could neither move the mass up or down, to the left, or to the right, with the amount of force I could command through digital manipulation, yet it distinctly moved with each contraction of the uterus and abdominal muscles.

The patient took her pains bravely, but for three hours there was no progress in labor, as the force of each pain was expended at the tumor, against which the head pushed. Finally the tumor was moved sufficiently to allow the head to engage at the superior straight. The patient remained during this time in Sim's position. After the head had passed the tumor the shoulders were caught, and a full half hour was consumed exhausting our mechanical ingenuity to disengage the fœtus. We succeeded finally, and the head and shoulders glided by the tumor to present a hard cicatricial, undilated os. The pains were strong enough to warrant dilatation, but the os did not yield an iota. I had concluded to incise it, because I felt sure the cicatricial tissue was

the result of the previous repairing of the cervix and produced the regidity.

Almost simultaneously with my resolve as I was standing about six feet from the bed, discussing with the doctor the advisability of such a procedure, we heard a distinct report like the snap of a piece of rubber. Examination showed that the cicatrix had been torn out in a V shaped piece, and hung by a mere thread to the normal cervical tissue. After this complete delivery was a matter of a few minutes. Post partum examination showed the tumor larger and above the cervix, and the fundus of the uterus rested upon it. I could not find the mass on the left. I was more assured than ever that I was right in urging the patient to have the tumor removed as soon as she had fully recovered from her confinement. The convalescing was uneventful.

I did not see her for a month thereafter when she announced she was ready for the second operation. On the fourth of March the second operation was performed. The median incision was made five inches long. A careful exploration showed the larger mass on the right firmly adherent, and placed just below the superior margin of the pelvis, and just off the line of the vertebræ. It had no connection with either ovary, broad ligament, or uterus. The ovaries and appendages were sound, and the tumor which had played so important a part as a cause for operating, proved to be the right kidney displaced into the pelvis. Firmly adherent, covered by peritoneum, it had been an easy decoy for the surgeon and a stumbling block to the doctors. It was somewhat oval, with vessels not more than three inches long, and was normally performing its functions, since all the examinations of the urine gave negative results. The position must have been congenital, not acquired, as there seemed to be no cause for the displacement.

The left kidney and other abdominal organs were normal in every way, and there was no sign of inflammation anywhere. The misplaced kidney did not present any cause for extirpation, and was accordingly not tampered with. There was no trace of the smaller mass on the left, not even a scar on the abdominal wall.

The abdomen was flushed, the wound closed with silk worm gut suture, and the patient left in a fine condition. She recovered rapidly without a noteworthy symptom. Her health was much improved, and the dysmenorrhœa had ceased after the miscarriage.

Aside from the error in diagnosis, the case presents many instructive phases. It shows conclusively that a correct diagnosis is imperative to an intelligent treatment of cases. (Think of the amount of galvanism that kidney received!) It has also added one more illustration to the

impossibility of correctly diagnosing obscure abdominal tumors without the aid of exploration, and that such exploration can be safely made though the uterus be gravid, and with comparative safety should the condition of the patient render it advisable and the surgeon be thoroughly competent.

There was not a single symptom, subjective or objective, in this woman's case that would have led one to associate the mass in the pelvis with a malposition of the kidney. Percussion over its normal area elicited negative results. The power of compensation which one kidney exercises when the other is diseased, or even absent, is so great and complete that simple displacements, congenital or acquired, rarely exhibit themselves during life, and not then unless complicating labor or operated upon for pelvic tumors. In all of such cases recorded, the symptoms have been so negative as to form no guide for future reference.

If a woman whose subjective symptoms indicated that the uterus or its appendages were the seat of disease should present herself for an examination, and a tumor should be discovered in the pelvis, it would be very natural to attribute her discomfort, and source of pain, to the proximity of the morbid growth. The most distinguished gynæcologists have failed to recognize in the pelvic tumor, accompanied by a sense of weight, dragging pains of a neuralgic nature in one or both sides and following down the course of nerves and aggravated at each menstrual nisus, a displaced kidney. Abnormally placed, but normally performing its functions, it does not remind you that healthy organs are sometimes curiously misplaced. It is a fact, however, that kidneys, through some freak of nature, possessed of normal functions in abnormal positions, have been treated for some hypertrophic condition of the pelvic viscera. Many of these cases yielded to treatment, and although the tumors were not absorbed, they were not the source of any discomfort after the local symptoms produced by the metritis or ovaritis abated; and the patient was accordingly left until more pronounced pain, or absolute danger, should demand radical measures.

Such a patient is not apt to have symptoms pronounced enough to warrant operating, and will eventually die with some acute malady, without ever knowing the character of the tumor which had been credited with augmenting, if not causing her physical ailment.

However singular it may seem that experienced practitioners should so frequently err, with the records plainly demonstrating this contingency, they all declare that with the greatest care and most precise knowledge, it is impossible to avoid such an error. The

remarkable adaptation which nature exercises, renders it possible for a negative mass to occupy an abnormal position in the pelvis without giving rise to any inconvenience or distinctive symptoms, and still be to the objective mind the cause of all physical suffering. The histories of such cases among modern writers are those where the tumor has been diagnosticated as belonging to the uterus or its appendages, but when operated upon was found to be enlarged liver, spleen, or some pathological condition entirely removed from that diagnosed. Prepared as the surgeon is for any situation it is not a matter of much moment whether the diagnosis be correct or not; for should the tumor be removable, he will operate; if not, the abdomen will be closed and the patient left to her fate, but rarely be any the worse for the exploration.

Modern surgery has been of incalculable benefit to the gynæcologist in making exact diagnoses. Through it, we have become cognizant of pathological conditions, and their symptoms, which formerly autopsies alone revealed; and have been able to correct incipient diseases by their early recognition.

There are many fallacies connected with the diagnosis of abdominal tumors, and gynæcology proves nothing more plainly than the possibility of being mistaken, and that a correct diagnosis is essential to correct treatment.

DISCUSSION.

H. F. BIGGAR: Anæsthesia will frequently help you to make your diagnosis without an exploratory incision. I am surprised that the urine showed no disturbance, for the authorities agree that it would be affected by a movable or a floating kidney.

A. LENORA WHITE: This kidney was not movable except under very great pressure. It was congenitally much lower than normal, was covered by the peritoneum and normally performing its function.

W. B. VAN LENNEP: A man was seized somewhat over a year ago with a very acute attack, was getting worse, and laparotomy was determined upon. Before the operation careful palpation made out a distinct tumor. It was supposed that this was the ordinary tumefaction or abscess. On opening the abdomen, however, there was found to be no adhesions but an appendix which was becoming gangrenous. The tumor, that was floating, proved to be the right kidney, which lay in

the pelvis apparently normal—in its abnormal condition, as has been properly stated—with no adhesions and covered with peritoneum. I will say further that the urine had been examined and no abnormality found. I should certainly endorse that such a kidney ought to be left alone.

E. G. TUTTLE: Just one word in corroboration of what has been said regarding the fact that, notwithstanding the authorities to the contrary, floating kidneys or misplaced kidneys do not always yield an abnormal urine. About a year and a half ago in the Flower Hospital there was a patient who was admitted for a tumor which, under several examinations, was pronounced to be ovarian. At a subsequent examination, two days previous to the operation, the tumor could not be found, which was a mystery at first, but on subsequent examination it was found that it was a floating kidney, which could be forced down to the lower part of the abdomen. The patient was kept under observation for about three weeks; if I remember correctly the urine was examined daily, it was normal in quantity. We had three chemical tests, and during that time there was no abnormality whatever in the urine. The patient only obtained relief when a tight compress was placed over the right side, keeping the kidney tight up, as near as possible to the normal position. No operation was required and the patient left the hospital comparatively in the same condition that she came in, excepting that when the compress was worn she was relieved of the dragging and bearing down which she had experienced before. This I state simply to show that misplaced or floating kidneys do not necessarily produce changes in the urine, although I think the authorities are well settled that they generally do.

F. E. CALDWELL: In conjunction with this same line of thought I would say that I have had a case of floating kidney under my observation for ten years. I have examined the urine frequently and it has always been normal. The patient does not suffer any great amount of pain, except when the kidney presses upon the pelvis and then it is easily replaced and she has no trouble. I have watched her for ten years, and physically she has been entirely well.

Dr. WHITE: One thing that I would call attention to is the adhesions; as the woman gave a specific history I think that was quite cause enough for them. They were not produced by the electricity; the left ovary was a little enlarged, there were no adhesions on that.

THE RESPONSIBILITY OF THE PHYSICIAN IN THE TREATMENT OF OBSCURE PELVIC DISORDERS IN WOMEN.

B. F. BETTS, M. D.,

PHILADELPHIA, PENN.

From the fact that prominent and distressing symptoms, attributable to pelvic disease in women, may be frequently *relieved* by the administration of internal remedies alone, a correct diagnosis of these conditions is often neglected. While this may be partially due to the refusal of patients to submit to an examination, if *relief* can be thus afforded, a desire upon the part of the physician to be more fully informed of the nature of these affections, would overcome their objections in a large proportion of cases, in which the gravity and obscurity of the case demands it.

Organs which are liable to become diseased, through influences purely mechanical, require mechanical, as well as medical treatment, and a female who has fallen and dislocated her reproductive apparatus is as much in need of surgical aid as though she had dislocated a hip or shoulder, and yet it is the prevalent custom to merely prescribe for these cases, until pelvic engorgement and inflammation ensues, and an almost hopeless condition of invalidism is induced. Such accidents are liable to occur at any time of life but are especially likely to befall the young and active. It is then that the functional action of the reproductive organs is seriously interfered with, for following in the wake of a simple descent of the uterus there is often a flexion of the cervix upon the body which, with the engorgement that ensues, produces a constriction in the canal of the cervix, with imperfect discharge of the menstrual flow, dysmenorrhœa, endometritis, involvement of the tubes and ovaries, subsequent sterility and no end to general systematic disturbances. A badly treated abortion, with the uterus displaced, may lead to serious disease, if infection follows its natural path from the endometrium, by way of the fallopian tubes, to the ovaries and the pelvic peritoneum. Injuries to the parturient canal at childbirth are overlooked, and serious consequences ensue, which take time and subsequent surgical treatment to rectify.

These are but a few illustrations of the consequences attendant upon the habit of treating such patients without thoroughly understanding

the nature of the diseased condition present in each particular instance. While there is no part of the practice of medicine so likely to be neglected, there is none requiring the exercise of more discernment and skill than that pertaining to diseases of the pelvic organs. There is also none so capable of repaying the conscientious practitioner by good results for suffering women, than the skillful gynæcological work, and while denouncing most strenuously, all unnecessary examinations the necessity for a careful diagnosis of obscure cases must be insisted upon, and as this can be effected in many instances by a physical exploration per rectum, quite as well as by that per vaginam, there is no good reason for restricting such investigations to married women alone. The physician's responsibility does not end with the prescription he makes of the medicine required, but must extend to the recommendation of such measures as are known to be efficient, from the experience of the past.

To smother pain by the administration of a narcotic while the disease makes more rapid progress than before, is the custom of one system of practice, while the habit of entrenching oneself behind a barricade erected upon one's experience in relieving pain by the homœopathic remedy, is a method almost as hazardous.

From the fact that the nature of these pelvic disorders lies hidden behind the panoply of a woman's sexuality, and to be able to diagnose them, one must have considerable practice in order that the tactile sense may be educated to the utmost limit of its ability to picture to the mind the evidences of the conditions present, many cases which would be easily understood by the specialist remain undiagnosed by the general practitioner, and it is here that the services of the gynæcologist are needed.

Although there is at this age but few, comparatively speaking, who are actuated by a feeling which finds expression in the statement, that it does not pay to "farm out" cases to the specialists, there are men who have not grasped the whole of the science and art of medicine and surgery, in general practice, who let patients suffer in consequence of this actuating motive. Upon these a grave responsibility rests. It is not the specialist who sees these patients after the mischief is done who should shoulder the whole of the responsibility of an operation or a long siege of medical treatment.

The most charitably disposed will but share the responsibility with the general practitioner. At the forum of one's conscience must be decided the nature of the treatment applicable for each case, and it is neither from the plaudits of those who have been cured by some obscure

affection by the knife, nor the claims of those who have escaped such mutilation, that just conclusions can be reached. It is after a correct diagnosis has been made and a careful consideration of the feasibility of homœopathic treatment convinces us of its inefficiency, that gynæcological surgery steps in, as the hand-maid of our art and a boon vouchsafed by the enlightenment of this age to suffering womanhood.

To fully appreciate our responsibility, in the treatment of these cases we bear in mind the fact, that an operation which would have been attended with but little risk to the patient if performed early, becomes much more difficult and much more hazardous from delay. These remarks apply to all conditions extending from a simple dysmenorrhœa to pus-tubes or bleeding fibroids and tumors of all kinds, be they cancerous or benign, and with the mind full of the wonderful results gynæcological surgery is accomplishing under favorable conditions, the experienced surgeon finds that one of the most important questions for him to decide is "when to operate." Actuated by a desire to do the best for the patient, he must, of necessity, operate as soon as he is convinced that other treatment must fail to cure. So evident is it to my mind that many pelvic diseases, not amenable to medical treatment, grow speedily worse from delay, that I would formulate the statement "when in doubt, operate." But this doubt should approach as nearly as possible a conscientious conviction, based upon such conclusions as are drawn from careful study and experience. The progress of medicine is threatened most seriously by the lack of careful painstaking diagnosis, for we find persons hazarding statements attributing to medical treatment the most wonderful results who have failed in this respect.

I yield to no one in the appreciation of the efficacy of homœopathic treatment, but protest against basing its claims upon untenable ground. With accurate diagnosis who can doubt but that wonderful revelations of its efficiency may be made and much that is now surgical may be relegated to the class of medical cases, but we want honest proof to establish these claims. The responsibility resting upon us is in the direction of careful prescribing and careful diagnosis and the adoption of such mechanical and surgical measures as will remove obstacles to medical treatment.

DISCUSSION.

H. M. PAINE: I would like to ask what mechanical means the doctor would advise.

B. F. BETTS: Presuming of course that the case is one in which replacement can be readily and properly effected without injury to the patient, I would resort to such mechanical appliances as would keep the uterus in place, selecting for each individual case the most appropriate instrument. None of us can tell beforehand what would be required in a case of displacement. There is a multitude of instruments, and from this multitude we make our selection, but pessaries and mechanical appliances are just as important in my mind as crutches and canes are, but like crutches and canes they should be dispensed with as soon as the patient can get along without them, and the great trouble from the use of pessaries arises from their being misapplied, when conditions are present which indicate medical treatment, and because they are left in too long. All patients should be examined frequently and be led to do without the pessary treatment. But on this point of trying pessaries and attempting to replace organs in spite of all obstacles, let me say one word. Hahnemann's idea is the true one in this respect, as in almost every other respect, that we must relieve the last appearing symptoms first, and in case we are called to see a patient suffering from uterine displacement, we must take into consideration those symptoms which have developed last. For instance, if she is suffering from inflammation, as a result of long continued displacement, that must be removed first of all by rest and by the indicated homœopathic remedy, and when she gets into condition admitting of the application of the pessary, the pessary is good. Without she is in that condition the pessary will do her a great deal of harm.

DR. PAINE: This is a subject to which I have given considerable attention. It seems to me that we ought to recognize in connection with the displacement the fact that there exists oftentimes in connection with it a tonic spasm at the neck of the uterus.

For the past fifteen years I have treated such cases—especially where there was a slight curvature—with an intrauterine stem pessary. At first I used an ordinary pessary and also inserted a rubber tent with a shoulder. But this would after a time cut its way into the cervix, and the pessary would press on the rectum, so I devised this [exhibiting a

specimen] which keeps the stem in place by means of a spring, yet is easily introduced and removed. It can be worn for months, and larger stems can be fitted from time to time as necessary.. The stem is usually at least ⅝ of an inch in diameter—two or three times a week the instrument is removed for the application of local treatment—I have used it in patients of all ages from fifteen to beyond the climacteric.

R. BOOCOCK: This would prevent conception, and I consider pregnancy—with good care afterward—the best treatment for these cases. I use cotton tampons instead of pessaries.

DR. PAINE: Let me state that the cotton tampon is a snare and a delusion. This pessary is graded so as to lift eleven ounces, and that is not sufficient in some cases. I defy any human being to put in a cotton tampon that will straighten a uterus bent to that extent, it is simply time wasted. You cannot restore the bent uterus by packing the vagina. Would the doctor think of dressing a broken arm by simply putting cotton on the shoulder? We must make our application at the seat of trouble, and the tent has got to be inside the womb; the thing is to have a tent that will not do much harm.

(In response to a question:) My tent pessary does not interfere with menstruation, nor cause pain—although in some cases the patient can only wear it a few hours at a time until the womb tolerates it.

DRAINAGE AFTER LAPAROTOMY.

HOMER I. OSTROM, M. D.,
NEW YORK.

The subject of drainage in abdominal surgery is not a new one, but it is one that for many years to come will bear discussion and re-examination, for in the first place we do not yet know just where to drain, and in the second place we have not determined the best method of applying the principle of drainage.

To these two phases of the subject, I ask your present attention.

The advantages of draining the abdominal cavity after it has been opened no one will now deny. It has undoubtedly saved many lives, and has as certainly in many instances shortened the period of convalescence and made the operation a surgical success; that is, has enabled us to declare the operation to have been performed according

to the most scientific methods, and hence has been a means of excluding the phenomena attendant upon pus formation, which constitute one of the opprobriums of surgery. All this is readily conceded, and still the cases in which we should drain, and those in which we should not, are, or should be, very clearly defined, for I am convinced that the drainage tube when used unnecessarily not only retards recovery and healing, but is actually harmful. I will not go so far as to say that the result is even fatal, but I have been led to conclude that more or less grave intestinal complications have arisen, that could with reasonable certainty be traced to the use of drainage, proved by the subsequent history of the case to have been unnecessarily employed. I refer to the altered relations of the abdominal, more especially the pelvic, organs that must always follow the presence of a drainage tube, or any other method of effecting drainage. This follows in every case if the drainage is maintained long enough to accomplish its purpose, for within a short time after the operation, the canal is shut off by adhesive inflammation from the general abdominal cavity, and this new tissue effects the relations of the intestines and other organs to a degree that corresponds to the manner in which it has disturbed their normal position. But when drainage is called for, the advantages greatly outweigh any possible disadvantages. Our aim, however, in abdominal surgery is not to do well, but to do the best. Not merely to save life, but to restore health. I fancy if our statistics were compiled with these results in view, the showing would not be as creditable as it is at present. How many women pass successfully through a laparotomy, only to become invalids during the remainder of their lives? I think our statistics should be so constructed as to place such cases, and results, in their proper light.

No one can appreciate more fully than the abdominal surgeon, the difficulty of formulating any rules to guide him in the use of drainage. The theory is simple and is in no wise different from that which applies to surgery in general. No fluid, the result of an operation, can with safety be allowed to accumulate, much less remain, in any part of the body; and when we began to regard the abdominal cavity and the peritoneum in the same light that other operable tissues have been looked upon for years, it required but a step to apply the principle of drainage to this department of surgery; but just *when*, *where* and *how*, were questions that received but faint answers from the knowledge gained from general surgery.

In deciding when to introduce drainage in abdominal surgery experience will be of great assistance, but in no department of our art

will natural surgical instinct come to our aid more successfully than here. We may drain where there has been an accumulation of fluid or where we have reason to suspect that fluid will accumulate; or where there is suspected hæmorrhage; or we may drain when we have been obliged to wash out the cavity; all this is clear sailing, but not every case in which the abdomen has been flushed calls for drainage, indeed in some instances, I consider it a decided advantage for water to remain in the cavity. In the first place, by that means the intestines are for a few hours following the operation kept apart, and hence the danger of inflammatory adhesion is to that extent reduced, and if there has been any great disturbance of the intestines they will return more quickly and more certainly if surrounded with fluid than if the peritoneum is kept dry; have also sometimes thought that the intense thirst that always follows a laparotomy was less hard to bear when some water was allowed to remain in the cavity. I am, therefore, by no means anxious, unless I suspect or anticipate hæmorrhage, either to remove all fluid, or to introduce a drainage tube even when I have considered it necessary to use free irrigation.

But there are cases when neither fluid has existed, nor hæmorrhage is looked for, when the abdomen is supposed to be surgically clean, cases in which the operation has been of the simplest character, scarcely more than exploratory operations, that are among the most appropriate for drainage, and in which drainage contributes in a large measure to the very brilliant results that follow such operations. Here I think we are on quite safe ground in deciding for or against drainage. If the operation has been performed for any one of the numerous inflammatory diseases of the appendages, especially in cases of badly damaged appendages, I look upon drainage as a most valuable adjunct to the operative procedure. How it can assist in restoring health to the pelvic circulation is more a matter of conjecture than a fact itself. My own impression is, that we have here the same series of phenomena that attend draining the peritoneal cavity when hæmorrhage from torn adhesions continues. Mr. Tait has shown this to be one of the most efficient means at our command for controlling troublesome oozing from torn surfaces, and has offered the explanation, that by extracting fluid from the tissue we contract muscular fibres, and especially those that belong to the smaller arteries. In this way drainage may relieve pelvic congestion, a condition that in a certain degree always attends damaged uterine appendages, and frequently follows operations upon the re-productive organs.

I have in several exploratory operations performed for the purpose of diagnosis, or in the hope of removing the source of suffering, when I have found it either impractible to remove the diseased organs,—and I am not easily deterred from accomplishing my object—or when no organ existed sufficiently damaged to suggest removal, effected most brilliant cures of the pelvic pathology, that is, of the pain and suffering attendant upon the exercise of the re-productive functions, by introducing a drainage tube for twenty-four or thirty-six hours. I have been astonished at the rapidity with which such cases are relieved and the permanency of the cure. I am well aware that such cures are sometimes effected by simply opening the abdomen and separating some of the adhesions but when the congestion is of a high degree, and when it involves the pelvic organs as well as the peritoneum, I regard drainage, maintained for a short period, as a most valuable adjunct to the cure.

The questions of *where* and *how* to apply drainage naturally overlap each other, for a consideration of one involves a consideration of the other.

The vagina is the anatomical drain for the pelvis; for all drainage, unless there is some particular point developed by the operation, should reach behind the uterus, as fluid naturally falls into that place. But practically drainage through the vagina has not been attended by the success that upon anatomical grounds one is led to anticipate. This probably arises not from any fault of the mechanics, but from the danger of septic infection through the vaginal canal. With our present knowledge this danger should be reduced to a minimum, for it is possible to make the vagina as aseptic as any other place through which we desire to use drainage. Therefore, if for other reasons it seems wise to drain through the vagina, I never hesitate to do so, but certain precautions must be observed. In the first place, the vagina, before any abdominal operation—for it is never possible before a laparotomy to say how he will drain—should by douches be made aseptic. In the second place, the drainage tube must be of such kind and so introduced as to leave no possibility of its being forced out before the period of drainage is complete. All who have attempted to use vaginal drainage will recognize the truth of this, and the difficulties its accomplishment involves. Any smooth tube will early be forced out of the vagina, thus leaving an opening in the vaginal vault that is extremely difficult to find, and into which it is almost impossible to re-introduce the same tube, but an opening that is sufficiently large to serve as a door for infection.

I have reduced my methods of vaginal drainage to two: the rubber tube fashioned in the form of a latin cross, and iodoform gauze. The former I employ in cases of ordinary pelvic drainage, that is to say when I consider it necessary to drain through the vagina after laparotomy; the latter—iodoform gauze—I employ after vaginal hysterectomy. This operation as you may know, I perform with clamps in preference to the ligature, and I do not sew the peritoneal flaps together. I accomplish drainage by packing the vagina, not too tightly, with iodoform gauze, and I have yet to record my first death from the operation.

From my success in my last series of laparotomies, in many of which I used vaginal drainage—the latin cross tube—I feel a confidence in this method that I did not feel formerly. In pelvic hæmatocele—extra peritoneal—in ruptured extra-uterine pregnancy, I prefer it to the usual abdominal drainage. It is sometimes advisable to employ both methods, but I rely most upon the vaginal tube to keep the abdominal cavity free from dangerous fluids and secretions.

It is probable that abdominal drainage will for some time to come remain the most frequently applied method, for it is all that is necessary in the majority of cases and does not involve additional mutilation; the severe laparotomies, however, frequently require something more, and here vaginal drainage deserves consideration.

We cannot go far astray if we observe the general rule to apply drainage wherever it is necessary, that is to say, at a point where there is anything to drain. It may, therefore, occur that several drainage tubes are introduced passing in various directions, but introduced through one opening. For this purpose glass tubes with different curves are the best. But as fluid to be discharged from a tube passing through the abdomen flows against gravity we must suck the fluid out, or avail ourselves of capillary attraction. For the latter purpose, wicking made aseptic is introduced to the bottom of the tube and left hanging from the free end. When the fluid is devoid of clots the object is by that means accomplished. But in deciding to use an abdominal drainage tube we have to consider the behavior of the surrounding tissues in relation to the foreign body, for it is probable that in very many instances the tube as usually introduced fails to accomplish all that is expected of it because of the behavior of these same tissues. It, for example, is probably true that within twenty-four hours or less time, inflammatory new formations develope to such an extent about the tube as to completely shut off the abdominal cavity and so reduce the area of drainage to the immediate vicinity of the tube; if the location

it is desired to drain is small, the tube so introduced will accomplish its object, but if we seek to drain the peritoneal cavity generally, I think we must adopt other expedients. I have sometimes first introduced a square of iodoform gauze to the bottom of the pelvis, and in the centre of that a glass drainage tube, and by this means I have thought that to a certain extent I prevented the tissue from forming and the intestines from closing the small perforations of the tube.

I find nothing that meets the requirements of drainage as well as iodoform gauze. This may be introduced in small strips or by the yard, there is absolutely no limit to the quantity that may with safety be used. I have literally packed the cavity with iodoform gauze, shutting off the abdomen completely from the pelvis. The material gives rise to no irritation, and if packed loosely provides perfect drainage. In one of the most difficult and unpromising cases of extra-uterine pregnancy I have ever operated on, where it was impossible to remove all of the suppurating fœtal sac, in connection with vaginal drainage I used three abdominal tubes and five yards of gauze, by this means draining as many pockets in the pelvis and building a wall between it and the abdominal cavity. The lady made a complete and rapid recovery.

One objection, however, may be urged against gauze drainage, the difficulty of removing it. This sometimes gives rise to extreme suffering and may even require the use of a little ether, but if the gauze is allowed to remain long enough, it is removed with comparative ease and with much less pain to the patient. If a little is drawn out each day after it becomes apparent that the period of drainage is near an end, much suffering is avoided and the canal made by the drainage heals from the bottom.

In closing let me apologize for this very brief throwing together of a few thoughts connected with a very important subject; I trust the other members of the society will supply my deficiency.

DISCUSSION.

H. F. BIGGAR: There are two or three points that occur to me in the reading of this paper, and one which I have found to be very useful is that the use of the drainage tube admits air into the abdominal cavity, and air is a hæmostatic. Cases of hæmorrhage have been relieved by the insertion after the operation of drainage tubes. In the abdomen

a short drainage tube is better than a long one. I very seldom use any water in the abdomen but keep it dry by dry sterilized cotton sponges. Float the bowels in sterilized sweet oil, the last thing you do, and adhesions will be prevented. I have found no better way than the flushing the colon with warm water, from 100° to 105°, is a natural way to stop thirst. In regard to the iodoform gauze, I am very glad to hear that the doctor has so ably explained the way that iodoform gauze should be used. In packing gauze I have found it very annoying, but I see where I erred. I took it away too soon.

THE RECTAL MUCOUS MEMBRANE AS A MEANS OF PREVENTING INFECTION IN OPERATIONS ABOUT THE ANUS.

WILLIAM B. VAN LENNEP, A. M., M. D.,
PHILADELPHIA, PA.

I reported last winter some cases in which, to prevent infection after repairing complete lacerations of the perineum, the rectal mucous membrane was first loosened around the tear, drawn down over the stitches on the bowel side of the perineal body, and fastened to the skin.*

Every one who does the operations of Pratt and Whitehead, or modifications of the same, has no doubt been impressed with the extreme mobility of the rectal mucous membrane, which can be brought down to cover quite extensive raw surfaces. This fact, as well as the frequent failures from infection in the operation ordinarily practised, led me to undertake the procedure referred to in repairing perineal tears, and subsequent trials have been uniformly successful, in other hands as well as my own.

Encouraged by these results I have attempted to extend the use of the drawn down mucous membrane as a means of protecting the wound, to other operations about the anus. There is perhaps no lesion in this region in which quick and complete union is more desirable than in rectal fistula. At present the most approved measure for accomplishing this end, excision and suture, presents the same objections as the operation usually performed for complete tears of the

* Hahnemannian Monthly, March, 1892.

perineum, infection from the bowel. By applying the same principle, plus excision and suture, to rectal fistula and abscess I have been able to secure union by first intention in six out of seven cases operated this spring and summer. A point to which I desire particularly to draw attention is that such a protection has been obtained without necessarily doing a partial (Whitehead) or a complete (Pratt) excision of the pile bearing ring at the same time.

The cases operated resolve themselves into two classes.

In five there was a single fistula, starting at a varying distance from the anus externally, and opening from three-quarters to one and a half inch up the bowel. In none were any hæmorrhoids removed. Two patients were undoubtedly tubercular, such cases notably healing slowly when operated in the ordinary way, and the patient often running down rapidly. Hence the idea so many have that anal fistula should not be operated.

The bowels were thoroughly purged, and the rectum cleansed by repeated enemata of permanganate of potash. The anus was dilated and the fistulous track was laid open in the usual way. All inflammatory tissue was completely and freely excised, leaving a healthy raw surface. Bleeding vessels were tied as they spurted. Such a free excision necessitated cutting into the sphincter, which was completely divided twice. The rectal mucous membrane was loosened all around the incision which laid open the fistula, its edges seized with T forceps and drawn down and to the opposite side of the anal orifice. The raw surface, the divided sphincter, and the skin wound were then accurately closed with a buried continuous suture of catgut, layer by layer. Finally, the drawn down mucous membrane was fastened to the skin by stitches passed a half inch or more from its free border. This was to prevent too early retraction by the sutures cutting out. A small strip of gauze covered with collodion, or Socin paste were used as a wound dressing. Iodoform gauze was packed into the anus to avoid infection during the first twenty-four or forty-eight hours. The bowels were allowed to take care of themselves, and, if not moved by the fifth day, recourse was had to an enema and a mild cathartic.

The result in each case was primary union, the patient getting out in a week or less. There was, however, in all a rise of temperature for a couple of days, in one instance almost necessitating opening the wound. Such rapid wound healing is certainly an improvement over the slow process of granulation following the ordinary operation, to say nothing of the avoidance of incontinence, for the sphincter can be fearlessly divided as it is immediately sutured.

In two cases the condition was much more complicated and was due to long continued tinkering with injections and "ambulant" treatment of piles.

1. Male, about forty years of age, with a fistula on the left side, the inner opening an inch and a half up, and a perirectal abscess of moderate size posteriorly. The outer opening of the fistula and that of the abscess were close to the verge of the anus, and the mucous membrane for fully an inch was friable, swollen, and œdematous. The man was much emaciated, unable to sleep on account of pain, septic, had profuse sweats, incontinence of fæces, and was barely able to come to the city with his physician, Dr. Phillips of Cape May. He had an annoying cough with bronchial breathing in both apices, and a weak heart.

A ring including the entire diseased mucous membrane was resected, the fistula freely excised, and the abscess vigorously curetted and disinfected. The sphincter was accurately united, together with the two raw surfaces, by several layers of a continuous catgut suture. The rectal mucosa was then drawn forcibly down, and firmly and deeply attached to the skin border. Gauze was packed into the anus.

There was a smart rise in temperature for the first few days, but, instead of opening the wound, the bowel was frequently douched with lysol solution and hot applications of the same were made to the anus. The fistula and abscess healed per primam, in spite of some retraction of the mucous membrane from the extreme tension. This raw surface quickly cicatrized, however, and the result is a very gratifying one. There is no incontinence, and the appearance of the anus is normal, there being almost no evidence of the operation. He is in the best of health.

2. Female, forty-three years old, had developed abscesses and resulting fistulæ on the right and left of the anus in consequence of injections for hæmorrhoids. The fistula had been divided, curetted, and cauterized a number of times, and the sphincter was cut on the left side producing complete incontinence of fæces. She had been in bed five months, was completely exhausted, septic, sweated profusely, and the urine contained sugar. She was vomiting constantly, and had an almost continuous, watery diarrhœa. As she could not be nourished and was sinking rapidly she was operated.

The ulcers were excised, together with the diseased mucous membrane; the raw surfaces and the ends of the sphincter were then

accurately united with catgut, and, finally, the rectal tube drawn down and stitched to the skin.

When the catgut absorbed but little union had taken place, and the wound gaped considerably. Under anti-diabetic diet and appropriate medication healing has taken place, but it is too early yet to give an opinion concerning the sphincter. There is still some incontinence of gas and watery stools, but they give her warning and she can evacuate ordinary movements naturally. A point gained, in spite of the partial failure of union, was that two angry ulcers and the rotten end of the rectum were transformed into a smooth, clean, granulating ring which closed rapidly as soon as the sugar disappeared. Such a ring always heals kindly. Her general health has improved wonderfully.

From this experience it seems to me that the rectal mucous membrane can be frequently employed as a "protective dressing" for wounds about this "cesspool" of the body. Besides complete perineal tears, the procedure will be of use in those incomplete lacerations producing recto-vaginal fistula which are so difficult to close.

In rectal fistula and abscess, however, this measure will find its most frequent application. No matter how extensive they may be externally, if they can be excised and closed, their rectal aspect can be protected.

In fistulæ with a tortuous course internally, which in other words run around the bowel, the overlying mucous membrane together with the diseased area can be excised, and the raw surface sewed and covered. Rapid healing will be obtained, even though tension be so great as to cause the mucous tube to retract after the first few days. Union will by this time have taken place sufficiently, and such retraction may be delayed by passing the stitches at some distance from the free edge of the mucosa, or by combining a deep interrupted with a continuous superficial suture.

I have as yet had no experience with fistulæ opening internally so high up as to preclude attaching the mucous membrane to the skin. I would venture to suggest, however, the plan I am about to follow in a recto-vaginal and recto-perineal fistula that may present such a difficulty. The mucous membrane is dissected loose, and the opening in it freshened and closed; after the rest of the operation is completed this point is shifted so as to prevent infection through it; or iodoform gauze is packed between the mucosa and the wound for twenty-four or forty-eight hours, a secondary suture of the former to the skin being then made.

DISCUSSION.

B. G. CLARK: Hot fomentation long employed (after operation) almost invariably softens the mucous membrane, and it gives out. Let it then be applied for an hour or two or only until pain is relieved.

A CASE OF PUDENDAL HÆMATOMA.

F. W. ADRIANCE, M. D.,

ELMIRA.

The condition which I have indicated in the title of this paper you will find also discussed by various writers as "Thrombus of the vulva and vagina," "Pudendal hematocele," and "Puerperal hæmatoma." It consists of a mass of blood, usually venous, effused into the tissue of the labia majora; or the areolar tissue surrounding the vagina.

It is most often found during the course of pregnancy or parturition, although it is claimed to have occurred in the non-pregnant state, and with no history of mechanical cause. Outside of traumatism, it usually is due to the engorged condition of the vascular system of the genital tract, operated upon by the descending part of the child, and the violent muscular contractions incident to the process of labor. Some authors incline to the view that a varicose condition favors the hæmorrhage, while others, among them Fordyce Barker, assert the belief that such a state operates materially to prevent it.

Usually but one of the labia are involved, and the extent of the invasion depends upon the amount of injury done to the vascular structure of the parts.

The majority of experience collated would seem to indicate that hæmatoma occurs more often after the completion of labor, than before or during that process. As to frequency of occurrence I quote from the "American System of Obstetrics." "Deneux was able to collect 62 cases, but had himself seen but three in a practice of 14 years. Paul Dubois saw one case in 14,000 labors. Winckel met six cases in 20,000 confinements. Hugenberger, 11 in 14,000 deliveries. In

Vienna it was noted 18 times in 33,241 births. This would indicate a frequency of one in 1,600 births."

The diagnosis usually can be readily obtained, if one is familiar with the fact that such an accident may occur at any time in the case of the parturient patient. Authors state that the pain is of a sharp, lancinating character, and if the tumor is external, and of any size, its general character, appearance, and location serve to identify it.

As to prognosis. Early writers on the subject inclined to regard such hæmorrhage, when of any extent, as a dangerous and frequently fatal complication of labor. At the present time a better knowledge of the character of the lesion, and consequently a more appropriate method of treatment, have served to greatly reduce the mortality of such cases.

If the tumor be small, it generally disappears without treatment. If large and with a recently delivered patient, the first danger is from hæmorrhage, if the sac ruptures, and later, should such rupture not occur, from septic infection or gangrene. If the hæmorrhage takes place within the pelvic space it may prove suddenly fatal from rupture into the peritoneal cavity.

Winckel summarizes the experience of puerperal hæmatoma as follows:

1st. Death from hæmorrhage with or without rupture of the tumor.

2d. Death following suppuration of the sac, and septicæmia most frequently after the sac has been opened.

3d. Rupture of the tumor with recovery.

4th. Rupture of the sac with a resulting fistula.

5th. Perfect recovery by absorption of the effused blood, without rupture of the sac.

In regard to the method of treatment to be employed in pudendal hæmatoma, authors I find vary. Fordyce Barker advises prompt action and says: "Although in some cases the tumor may be absorbed, yet, if it be of any considerable size, it seems to me that the danger from suppuration and from septicæmia is infinitely greater than the danger, with the styptics we now have at command, from hæmorrhage following the incision; and therefore the safe course is to incise early except when the tumor is high up in the pelvic cavity." Thomas says: "When the tumor is large, and experiment has demonstrated that it will not undergo absorption, it is advisable to evacuate the blood clot by incision." Hirst inclines to practically the same view as that given by Thomas. Skene thinks the immediate operation is preferable. Schroeder says with reference to incision, "It is best to wait three or

four days (the longer it is possible to wait, the less easily dangerous after-hæmorrhage occurs.)" Both Playfair and Cazeaux advocate delaying the opening of the sac as long as can be done with safety.

My personal experience is as follows: Was called to attend in confinement, Mrs. J—L—, age 22, primipara, on the morning of Aug. 8th, 1892. On arriving and making an examination, found the child presenting in the first position, os dilating well and, with the exception of weak and rather inefficient pains, the labor was proceeding normally. After waiting until 2:00 P. M., the pains not improving, the progress slow, and the patient becoming tired, I applied the forceps and promptly and easily delivered the child, anæsthesia not being used. The placenta followed readily, no force or manipulation being necessary to its removal. After the delivery of the placenta I examined the external parts with reference to any laceration and found none, nor any other abnormal condition. After remaining with the patient about half an hour after delivery of the child I returned to my office leaving her comfortable and resting quietly.

An hour later I was summoned in haste to see the patient, being informed that she was in great pain. On reaching her bed-side I found her very pale, pulse weak and fluttering, patient complaining of faintness and ringing in the ears, all the symptoms pointing to extreme loss of blood. On questioning I obtained no report of external hæmorrhage other than the lochial discharge. Pain of a sharp stinging nature located in the external genitals, with tenderness on motion or pressure, was bitterly complained of. On making an examination found a tumor the size of a child's head which involved the left labium major, extended up the vaginal canal as far as could be reached, and down to and back of the anal orifice an inch. The tumor very much resembled the head of a child pressing well down on the perineum. It was very firm and but slightly elastic. In color it was a bluish purple and shining. On questioning the patient she told me that soon after I left her, she felt a sharp twinge of pain in the labium, and on examining found a lump about the size of a walnut. This rapidly increased in extent and with it the pain became more severe.

Recognizing the serious state of the patient, and the condition being one I had never before met, council was at once summoned, and Drs. Morse and Jennings responded. The complication was new to all of us and after discussing the case and consulting authorities, as the hæmorrhage had apparently stopped, we decided not to incise the tumor for two or three days. A compress wet with hot ext. of hamamelis was firmly applied and suitable pressure obtained. Internally,

arnica 3x in solution in water was given, teaspoonful every hour. The patient suffered a good deal of pain during the first twenty-four hours and was quite feverish. Temp. at end of 24 hours, 102°, pulse, 120. Both pulse and temperature gradually decreased up to the 6th day, when there was a slight increase, temp. 102°, pulse 100. From this time both pulse and temperature slowly diminished till the normal in both was reached on the 19th day.

At a consultation held on the third day, it was decided best not to open the sac but to adopt the expectant treatment as the tumor had perceptibly lessened in size and the appearance was favorable. Also on account of the extremely weak condition of the patient, it seemed hazardous in the extreme to risk further loss of blood. From the outset the tumor steadily diminished in bulk, at first rapidly and then more gradually. The patient gained in strength, the lochial flow and the lacteal secretion were not disturbed. There were no chills, and had it not been for the slight febrile state before noted and the tumor, her progress would not have been other than what was natural with such cases. There were no symptoms of septic invasion except possibly the slight increase in pulse and temperature might have been regarded as such.

The future history of the case was uneventful up to the 8th of Sept. (exactly one month from her confinement) when on being sent for she complained that the tumor which at this time was the size of a large hen's egg, was becoming sore and pained her some. There was no evidence of suppuration, yet as it had apparently absorbed all that was to be expected, I decided it would be better to evacuate the cyst. This was done on the following day assisted by Dr. Jennings. The patient having been placed under chloroform, an incision was made in the sac at its most dependant point and the blood clot thoroughly turned out. The clot showed no tendency to organize except at one point where it was adherent. Neither was there any appearance of suppuration. There were probably four ozs. of the mass removed, more in fact than the external appearance of the tumor indicated. The cavity occupied by the clot extended up as far as the finger would reach and probably went to the brim of the pelvis. Suitable drainage was applied after the cavity had been washed with a bi-chloride solution and the walls brought in apposition by tamponing the vagina and using a compress. The patient made a rapid recovery, the wound healed kindly and promptly and within ten days of the operation she was able to ride out.

The experience in this single case, while it may prove nothing positive and might not serve as a guide in the management of some other similar

case, leads to the opinion that it is better to be conservative in action as regards the use of the knife. When full consideration of the size and extent of the effusion in the case stated is had, the exceedingly precarious condition of the patient at the time the condition was discovered, the fact that a very considerable portion of the blood was absorbed, that danger of further and serious loss of blood was avoided, that the patient had full time to recover to a large degree her strength, leads me to advocate incision at as late a stage as may be possible, always keeping in mind the fact that such cases need constant and careful daily observation, if not by the attending physician, by a competent hospital trained nurse. It also impresses me that the free use of hot ext. hamamelis frequently applied is a great benefit. My patient, under its use, speedily lost the pain and soreness, and I believe it, with the arnica internally, very materially operated to the final recovery of the patient.

REPORT

OF THE

BUREAU OF OBSTETRICS.

"Position an Important Factor in the Management of Parturient Cases." - - - - W. H. PROCTOR.
"The Forceps and Occipito-posterior Positions." EDWIN H. WOLCOTT.
"My Personal Experience with the Female Perineum." - - - - - J. H. HALLOCK.
"The Fourth Stage of Labor," and "The First Hours of Life," GEORGE WILLIAM WINTERBURN.

POSITION AN IMPORTANT FACTOR IN THE MANAGEMENT OF PARTURIENT CASES.

W. H. PROCTOR, M. D.

BINGHAMTON.

It is a well known fact that a large percentage of lying-in patients get up with displacements and subinvolution of the uterus. Not one physician in fifty gives a thought to the prevention of these troublesome conditions. This almost criminal neglect is the great opprobrium of the medical profession to-day.

The majority of physicians consider their duties completed when the cord is tied and the three visits paid the patient. She is then left in total ignorance of any requirements on her part. When no instructions as to position are given, most patients will, from natural inclination, lie upon the back the greater part of the time.

In this position the uterus almost invariably falls into the hollow of the sacrum—so soon as it is small enough to do so—with retroflexion and subinvolution the sure result. After the first two or three days every case should be directed to lie at least one-third of the time in the prone position and considerable time upon the sides, so as to reduce the time spent upon the back.

The nurse should assist the patient in turning, as any effort that is liable to strain the patient must be avoided. Digital examinations

should be made every few days during the four weeks the patient is in bed, to enable one intelligently to direct the case.

In case the patient has previously suffered from retroflexion and subinvolution, more careful watch—if possible—must be made, because of the liability of relapse.

This matter of position after childbirth cannot be too urgently insisted upon. Carefully carried out, it will almost invariably insure a correct position, perfect involution and freedom from congestion and inflammation.

THE FORCEPS AND OCCIPITO-POSTERIOR POSITIONS.

EDWIN H. WOLCOTT, M. D.,

ROCHESTER.

It is cause for congratulation that the obstetrical forceps are becoming more and more popular every year. The time was, and that not very long ago, when the objection to their use was so universal that consent was given with reluctance, even in cases where they were positively essential to the birth of the child and the safety of the mother. A very different state of affairs now obtains. It is noticeable by all physicians engaged in obstetrical practice that the opposition to the use of the forceps is the exception and not the rule in the practice of to-day. And not only the objection has been removed, but there is a growing tendency and desire on the part of the public, as well as among physicians, to increase the usefulness of the forceps and make their application more general. We are often urged and entreated to apply them where we know they are contra-indicated and their use would be entirely unnecessary. It will be admitted by all, that this change in public sentiment is due more to a better knowledge of the science itself on the part of the physician than to any special improvements in the manufacture of the instruments. The forceps of to-day are not materially different in construction from those made in the early part of the present century (with the possible exception of Tarnier's tracture forceps of 1877). The fact is we know better than ever before how to apply them, and are thus more entitled to the confidence of those committed to our care. There are, however, a variety of positions and presentations about which there is still discussion and difference of opinion. One of these is well worthy of our consideration here, and belongs to that class of cases where the occiput persists in remaining posterior, causing delays

and complications not only of themselves difficult to manage, but that imperil the life of the child and the welfare of the mother.

Lea Brothers & Co. of Philadelphia have just published a little work on obstetrics, written by Dr. Hayt, which contains a short statement concerning occipito-posterior positions that is so near my views of the causes and management of these cases, that I have chosen to reproduce it here:

"The causes that may operate to produce anterior rotation of the occiput in posterior positions of the vertex are: incomplete flexion of the head so that the chin does not come in contact with the sternum, an excessively large head, or a normal head and a justo-minor pelvis, and a very small head and roomy pelvis; the last class of cases is usually seen in premature labors, and as a rule, though rotation does not occur, the labor is no more difficult than it would be were the occiput anterior."

On the management of these cases he goes on to say:

"If complete flexion can be secured these cases will usually rotate, so our one object in their management is to promote flexion by upward pressure on the sinciput during uterine contractions. At the same time an attempt may be made to aid rotation of the forehead backward by pressing in that direction on the side which looks towards the pubes. Many cases of this kind occur where the rotation takes place very late in the labor, and not until the head is well down upon or bulging the perineum. If the labor is much prolonged, the energies of the mother becoming exhausted, and no rotation or descent is taking place, the forceps should be applied and the head drawn down to the perineum. The blades should then be removed and the labor allowed to terminate by the natural forces. Usually at this time rotation occurs and the case is practically the same as an anterior position. If the occiput is born posteriorly, the perineum is invariably badly lacerated."

It will be admitted, I think, that while the above statement may not and can not correspond to each individual case that will arise in our experience, it yet contains much that is valuable and reliable for our guide in practice. But strange as it may seem, "There are those who consider the application of the forceps in these positions as a doubtful expedient. Penrose, for instance, describes a condition in which the fœtal body is so firmly grasped by the uterus, (the child's abdomen and thorax being anterior) that rotation of the occiput is impossible, because the trunk can not rotate. He would resort to forcible rotation or craniotomy in occipito-posterior positions."

The majority of obstetric authorities, however, favor the skillful use of the forceps in these positions.

The case that I have selected to illustrate this paper follows:

Mrs. M. primipara passed through the first stage of labor before my arrival. Upon examination the occiput was found to be in the right occipito-posterior position. The pains were normal in character, but labor did not progress. After waiting a reasonable length of time, the patient was placed upon her back and prepared for an instrumental delivery. Chloroform was administered and the Hale, or short forceps, applied, on account of their convenience and not their necessity (for the more I use them the more I agree with Lusk when he says, "A good pair of long forceps renders the possession of short forceps a superfluous luxury"). When they were in position, the lock was closed and outside the vulva, their direction being along the sides of the pubes and in its axis, the left blade over the right brow of the child and the right blade over the left mastoid process. And while it did not occur to me at the time, I now believe that, since the head and pelvis were of normal proportions, the more skillful procedure would have been the oblique application. Notwithstanding this fact the results, as will be seen later on, were all that could be desired. Tentative traction was now made without any progress. More force was applied with frequent relaxation of the instruments to allow the head to mould itself and if possible to rotate spontaneously. Meanwhile the pains ceased entirely, under the influence of the chloroform, and appeared in the calves of the legs, regardless of the usual and additional irritation caused by the presence of the instruments. Thirty minims of the fluid extract of ergot were now administered to stimulate the uterus and cause a reappearance of the pains. After ten or fifteen minutes they returned to the uterus and were typical in character. The Hale forceps were now removed and the Hodge forceps substituted on account of their greater strength and their less liability to injure or mark the head of the child. Flexion, with steady and strong traction without the swaying or pendulum motion, were used for some time before the head reached the pelvic floor. When it had passed the inferior straight the forceps were removed to avoid rupturing the perineum more than the minimum amount. The next pain, with the assistance of my hand, gave birth to the child. As soon as the head emerged from the vulva, the face of the child turned quickly to the anterior, showing that the neck was twisted, and that the body was still in the same position as when the forceps were first applied. In due time the child was resuscitated, and the mother doing well. The perineum was only slightly lacerated, owing to the extreme elongation of the head caused by its passage through the parturient canal and the pressure of the forceps.

MY PERSONAL EXPERIENCE WITH THE FEMALE PERINEUM.

J. H. HALLOCK, M. D.,
SYRACUSE.

Preventing laceration of the perineum, when and how to repair, have recently been so thoroughly discussed in the "Homœopathic Journal of Obstetrics," that I'm sure but little new can be said. There only remains a chance for those having considerable personal experience to add their testimony, in what they believe to be the right direction.

This story like all others, has two sides to it, and *only* two. As a rule, *one way* or the *other* must be *right*. Of course, there would be exceptions to it.

Supporting the perineum I have tried in all possible ways, and while I think something may be done in this way, I know it's beyond reason to expect by this alone to prevent the rupture of unyielding, brittle or over distended tissues. The child's head must pass, the tissue having to go beyond the stretching limit tears, and we have the result to deal with.

I have been unfortunate enough to meet physicians who claim never to have had a tear beyond the fourchette and I have also operated on some of their patients, and I know some that will never be whole until they can be persuaded to undergo an operation. It has always been a mystery to me how physicians of good ability and integrity could overlook such cases. The only way I can see is, that they expect a tear or laceration if it existed must pass clear into the rectum, and finding the rectum intact they hastily take it for granted that the parts are as nature intended they should be. In the years that follow if they would stop prescribing blindly for the symptoms, and look for the *cause* of the cystocele, rectocele or prolapsus they couldn't fail to find a reason, and one that had occurred in spite of their remedies or perineal supporting.

Many ruptures occur in rapid labors and much can be accomplished by holding back the head at such times until the parts are fully dilated and ready to pass it through, then endeavoring to work it out between the pains. But there are other cases, especially primiparæ, where the parts are small and the fœtus large, and whether the uterus

contracts hard or not labor is necessarily slow and the accoucheur is sorely tempted to bring about rapid labor by use of the forceps. I believe in giving chloroform and using forceps before the patient becomes exhausted. But it's best to give nature her chance first, and in such cases I've had the most *gratifying* results from the use of vaseline. I have all cases supply themselves with a pound can of *vaseline* this when needed for use is reduced to a fluid state by heat, then with a one ounce hard rubber syringe (which I always carry with me), it is injected around and *above* the head. Only a little practice is needed to enable one to accomplish this to perfection, and the results that follow are sometimes astonishing. I have seen a head rotate and descend within a few minutes, when before it seemed immovably wedged in the brim of the pelvis. I have seen dry labors made quick and easy and its softening influence on the perineum seems to aid greatly in relaxing the parts and preventing rupture. Those who try it once will always keep themselves prepared for its use in the future.

But this or any other means will fail to always prevent laceration. It will sometimes happen and after it happens we can only decide on the best means of repairing, and after watching many cases I unhesitatingly say that there is nothing to lose by the immediate operation, while there may be much to gain. A few stitches deep and superficial can be placed by any general practicioner and with a reasonable expectancy of good union, if he doesn't forget to wash the parts and use free antisepsis. When the parts are numb and *evenly* denuded, with a few breaths of chloroform the patient hardly realizes it, and as she must stay in bed for a time, the chances are that without having been the least inconvenienced she will get up and find herself well. But suppose the parts have failed to unite, you now have the chance for a secondary operation just as if nothing had been done. But this going to bed a second time, taking an anæsthetic, and paying a big price for the operation, is so much dreaded by the ordinary patient that they would rather suffer for years than submit to it.

I have always had good success in my secondary operations, but I think I can obtain just as firm a perineum by the immediate. When the parts were natural to commence with and a tear occurs, the two raw surfaces must be *equal* in all their dimensions and if these two like surfaces are exactly fitted together and stitched there, with deep and superficial internal and external stitches and the tissues heal as mine usually have, you must get a perineal body very nearly resembling that before it was torn, and if it was strong enough then, it must be now, anyway it would be nearly as nature made it and that is hard to improve upon.

THE FOURTH STAGE OF LABOR.

GEORGE WILLIAM WINTERBURN, PHAR. D., M. D.,
NEW YORK.

The subject of the laceration of the perineum, and its repair, is one of much importance if, as has been claimed, few women escape this accident of childbirth. The three stages of labor have long been classic. but if there indeed be few women who pass through this ordeal without damage, then the attention they should receive after the birth of the placenta may well be dignified with the title of the fourth stage. It is perhaps owing to the fact of the non-recognition of the necessity of this attention which leaves so many women to suffer from an unrepaired rupture. The student is ordinarily taught that there are three stages of labor. Having secured the placenta he feels that his work is done. If he could be made to understand that his responsibility did not end here, that it was his duty to know just what was the actual condition of the vagina and uterus after the birth of the placenta, and that even a small laceration might be productive of serious immediate danger and of long continued suffering to his patient, a great advance in the practical application of our art would have been made. It is this careful supervision of the parturient canal immediately after it has been emptied of its contents to which I would apply the title the Fourth Stage of Labor. And I do this with no desire to be eccentric, but because it seems to me its importance has been hitherto ignored. This abrasion and disfigurement of the parturient canal has been treated as an accidental thing which it indeed truly is ; but an accident which happens so frequently as to be almost a matter of course deserves rectification in a methodical manner. To dignify this procedure, then, with the title of the Fourth Stage will not I hope, appear to give it more prominence than it deserves.

Let us then presuppose that the placenta has been delivered and disposed of satisfactorily. What then is the duty of the obstetrician to the woman in the case? He should, after allowing her a reasonable time for rest, say fifteen minutes or so, have every particle of soiled clothing removed, and her person gently but thoroughly cleansed This will not be done unless he oversees the job personally. The ideas of the ordinary nurse as to cleanliness are very much like those of

a man who takes a bath once a week—in his best estate he is never clean.

If the bed has been prepared and the woman's own clothing adjusted in a proper manner at the onset of labor, the soiled linen can be removed deftly and easily. Should the labor have come on suddenly, or the opportunity to make these preparations been neglected, the condition of the bed and of the patient's body linen will be much worse, but this only makes the change the more imperative. Every particle of soil and dampness must be removed, the clean sheets, night-dress and napkins thoroughly baked and put on while yet quite warm. If they can have previously been hung outdoors in the direct sunlight for some hours, so much the better. The external genitals, abdomen and thighs of the patient should be cleansed with water which has been boiled and has cooled to a temperature of 115° Fahr. This cleansing should be done with as little exposure to the air as possible; the surfaces which have been wetted being then rubbed with hot alcohol (alcohol 1; aqua bull. 2). This whole process of changing the linen and bathing should not occupy more than ten minutes' time, everything having been prepared during the moments the woman is resting. If the toilet is prolonged, the patient is exhausted unnecessarily.

The patient being now comfortable and clean, the doctor should proceed to examine carefully the condition of the uterus, vagina and perineum. If there has been laceration of the cervix it may usually be treated on the expectant plan, though if the edges gape apart a stitch or two, which bring the freshly torn surfaces in apposition, will do no harm, and are not troublesome to put in. Still a tear, which looks quite serious at the time, will often completely disappear during the process of involution without any treatment at all. Nor should it be overlooked that free drainage from the utterine cavity is a most important factor in normal convalescence, which must not be interfered with by the results of the operation. I am not, therefore, prepared to recommend immediate repair of the cervix to the practitioner inexperienced in operative procedure, though believing that in skillful hands it is a wise measure.

Laceration of the vagina is apt to be more serious, in both immediate and remote consequences, and these lacerations are almost always overlooked. They should be carefully searched for and repaired. The bruised and congested appearance of the tissues immediately after labor make it difficult to decide upon the existence or non-existence of a laceration. The trained finger will learn to detect them by the roughness and irregularity of the surface in the tear; but at first the

practitioner will have to depend upon eye-sight, and will need to so place the patient as to get the benefit of a strong direct light. By drying the surface with a bit of borated cotton, the roughened appearance will indicate the location of the tear. But he will usually be greatly surprised at the extent of the injury if he will seize the edges of the wound with forceps and draw them gently apart. If the wound is superficial, and does not involve the perineal body, a few catgut sutures will be all that is required. Not infrequently, however, the perineal body is injured, even the commissure remains intact.

While these rents in the vagina are of much importance, those of the outlet are no less so. These latter do not usually involve the perineal body, but are confined to the mucous and submucous tissues which overlay it. It is quite important that these rents should be at once repaired if they extend beyond the fourchette. Unfortunately, this is not done in most cases. Practitioners are too ready to believe that nature will take care of the case. But unless the edges of the wound are carefully coapted, the only healing that can take place is by granulation, and this leaves a weakened structure, ready to break down again at the culmination of the next pregnancy. It is these cases in which rupture has supervened on rupture which are apt to cause such serious derangement of health in after life. If properly treated there is neither loss of substance nor weakening of tissue, and the parts are as firm and as useful as before.

In the more serious lacerations, where the fibres of the perineal body are torn apart, or even the sphincter ani and rectum involved, the need of immediate repair is equally obvious. There may be circumstances in which delay is advantageous, but these are the exceptions. The more serious operations may be delayed in order to give time for the woman to react from the depression of a long-lasting labor, or in order to obtain efficient assistance or other desirable conditions. Such a delay of twelve hours, or even a day or two when necessary, does not take the operation out of the category of primary.

The primary operation for perineorrhaphy is much less formidable than the secondary, and has this decided advantage to the patient, that, when properly performed, subsequent parturition is less likely to cause a new rupture. The secondary operation is very apt to diminish the size of the vulva considerably, owing to the atrophy of the tissues during the months before the delayed operation, and the necessity of destroying tissue in order to obtain the freshened surfaces required. The narrowing of the vulva is, to be sure, an operative fault, but unless the surgeon is very skillful he will either do this

or fail to secure a functionally perfect perineum. It is not at all uncommon to see women whose perinei have the appearance of being perfectly restored, who yet have but slight control of the perineal muscles. The superficial tissues have healed, but the muscle itself has remained divided. The results are analogous to those by no means infrequent cases of concealed rupture where the perineal body has given way but the mucous covering has remained intact.

Of the various methods which have been devised for the repair of the injured perineum, it may be truly said that each has shown good results, and they may, therefore, all be said to be good. While the main question is as to the means by which the best final result may be secured, yet in the primary operation preference should especially be given to that method which requires the fewest assistants, the least elaborate preparations, and occupies the shortest space of time.

Although I advise that every lesion of the parturient canal should be repaired at once, whenever this is possible, I by no means deny that spontaneous cicatrization is possible even when the injury is considerable. Tarnier, Pajot, Pozzi, Guéniot, and others, have observed and commented on such cases, and in my own experience I have had knowledge of cases in which the power of the system to obliterate the evidences of a laceration has been unmistakable. Under good homœopathic medication, also, much may be done, and I am by no means as skeptical of the efficiency of this mode of treatment as most surgeons are. Yet in no one given case have we reason to expect so fortunate a termination of the accident, while even moderate skill can ensure, when aided by proper attention to the general health, a completely satisfactory result.

This is not the place for primary instruction in the methods of repair, and no one is justified in making the operation unless he has seen it done by a competent surgeon, and understands the principles of its technique. There are, however, a few suggestions which may properly find place here.

First, find out the exact state of the tissues. The wound is usually much larger than it appears to be. Carefully drying the surface and seizing the four corners of the wound with forceps, the edges may be drawn apart and the true nature of the wound disclosed. Repair must take place from below, the success of the operation depending upon coapting the torn muscular fibres. The nature of the tear will indicate the direction of the stitches, which must be put in with only moderate tension—just sufficient to draw the fibres into place. The torn surfaces must not be pressed together tightly, or their vitality will be injured.

It must not be forgotton that the parts will, in a day or so, become greatly swollen, and the wounded surfaces should have an equal chance to expand with the contiguous tissues. In this way union by first intention can almost certainly be secured. For the deeper sutures silkworm-gut possesses many advantages over silver wire. They should be tied as inserted. The superficial sutures should be cat-gut. These are needed to insure perfect coaptation of the skin and mucous surfaces. These latter will be absorbed and need no attention; the deeper ones are removed on the fourteenth day.

The common error in repairing severe but incomplete laceration is to treat it as a longitudinal tear of the posterior vaginal wall, when as a matter of fact it is usually a transverse tear at right angle with and immediately within the orifice. This more frequent form of laceration is occasioned by the outward and forward extension of the perineum as it is stretched by the advancing head, and begins as a rupture of the fibrous attachments between the levator ani and the submucous tissue. The contraction of the muscles causes a retraction of the upper (vaginal) portion of the involved tissues, resulting in the production of an irregular raw surface. This on inspection looks and feels like a longitudinal tear; but if the upper portion is seized in the median line with a pair of dressing forceps, and drawn forward and downward its true form will be perceived.

But such a simple transverse laceration of the attachments of the levator ani and other muscles from the muscles themselves is rarely seen. Generally this is complicated by the extension of one or both of its outer extremities upward along the vaginal wall, caused by the splitting apart of the fibres of the levator ani in the direction of their length.

In this particular form of laceration, which, as it does not involve the commissura, is so frequently overlooked by the "busy practitioner," I use the following simple procedure. It has the advantage that it can be done without anæsthesia, and with the sole aid of an ordinary nurse; but it can only be done immediately at the conclusion of labor and while the parts are yet benumbed, and the muscles have not firmly retracted. An extra large, fully curved needle should be used. This is made to enter through the skin just in front of the anus, and three-quarters of an inch from the median line, and, guided by a finger in the rectum, is carried directly upward in the recto-vaginal septum, about an inch or more, into the upper portion of the perineal body, and swept downward to correspond on the other side of the median line. The sutures should be buried throughout their whole length, that is they must not

show in the wound. If they do, it will be necessary to supplement them with a row of superficial stitches (continuous catgut) in the vagina. A second suture follows the first, in parallel, about one-third of an inch in front. From three to five such sutures will be needed. The external sutures are first put in but not tied. Then the vaginal ones, if these are necessary. These latter are secured properly and then the primary ones, in the inverse order of their introduction, are tied over a roll of gauze, care being taken to free the wound of clots before finally closing it.

In conclusion, while reiterating the statement already made that all lacerations of the parturient canal should, if the obstetrician is competent to undertake that class of work, be immediately repaired, I would enter a protest against that kind of midwifery which permits such lacerations. It is a disgrace to the obstetrical science of the day that any considerable portion of our cases fare so badly at our hands. Laceration is evidence of carelessness or incompetency if it occur often in any man's practice. Not every man who studies medicine can make of himself a skillful obstetrician. Most practitioners dislike midwifery, and only practice it because it seems a necessary adjunct to family practice. Any one who approaches any class of work in that spirit will fail to achieve the best results. Enthusiasm is the key which unlocks the door of success, and in midwifery this is eminently so.

I have recently discussed before the medical society of a neighboring state the relation of the perinæum to normal labor from the standpoint of the evolutionist. The argument in favor of the natural stability of that organ seems to be complete. The subject, however, is too important to be more than alluded to in this place, but I beg leave to append, as an expression of my matured opinion, the paper in which this is discussed.

THE PERINÆUM IN ITS RELATION TO NORMAL LABOR.

GEORGE WILLIAM WINTERBURN, PHAR. D., M. D.

NEW YORK.

The purpose for which the obstetrician exists is to furnish to the parturient woman, and to her child, the greatest opportunity for safety during the trying ordeal to which they are about to be exposed.

Even if that highest ideal of normal labor, as one in which extraneous assistance is not required, be attained by reason of perfect development and perfect health on the part of the mother, the birth of the child is still an ordeal to both mother and babe, the full significance of which is not realized by either of the participants. It is much more so under the circumstances as they actually exist in every-day experience. The dangers here to both are multiform, and are rarely so completely overcome as to leave no trace of their effects, if careful note be made of these.

In every department of mechanics it is deemed necessary that the workman should thoroughly understand his trade; and the success of the work done, as an example of wise expenditure of force, is proportional to the thoroughness of the workman's preparation for the duties he has assumed. It is the same in obstetrics; the careless or incompetent workman will botch his job. Unfortunately, it is as easy to cover up poor work in obstetrics as it is in building a house. The man who buys a house only to find his chimneys smoke, the plumbing unsatisfactory, the roof leaky, may have his remedy in the law, but he is a wise man if he pockets present loss, and invests not in that costly method of adjusting his wrongs. But the man whose wife or child has suffered at the hands of a blundering accoucheur is even less able to extract a recompense, and indeed, is more likely to be oblivious to the wrong that has been done, the full force of which only developes as time goes on.

The perinæum is so important a structure in its relation to childbirth as to deserve the most careful study on the part of him who would essay to guide a case to successful completion. It is so evident that he ought to know its minute anatomy, and the evolutionary methods by which it has come to be what it is, and the physiology of its functional life, that it seems but the veriest truism to mention it. And yet how many of the fifty thousand men in these United States, who attend one million confinement cases annually, have any such knowledge or any comprehension of its necessity? It is not enough for him to know the names of the perineal muscles, or the sources of their blood-supply. So much is desirable, but he must go beyond this, and be able to project subjectively the modes of action by which they perform their work under the stress and strain of labor. Unless he can do this he is not master of the situation.

I do not intend in this place, and before so intelligent a body of physicians, to describe the anatomy of the perinæum, or to demonstrate the manner in which it fulfills its function. I can readily believe that

everyone within the sound of my voice understands these things quite as well as I do, for it is here in our state meetings that we find assembled the best of the profession. While I presume you have here, as there are in all societies, a few wire-pullers, who come regularly to the meetings for the offices they can get, yet the bone and sinew of the association, here again as elsewhere, is doubtless made up of the progressive, conscientious, educated medical men of this commonwealth, who desire not so much to benefit themselves as to lift the standards of medical practice to a higher level, and are willing to sacrifice present profit, and somewhat of ease and comfort, to come up to these meetings. If I speak then of self-evident things it is that we may bring our collective influence to bear on those other fellows—the thousands that are not here.

My theme then is the perinæum in its relation to the conduct of a normal case of labor. And I premise, as the basis of all the help the physician can give, an intimate knowledge of that structure which has been picturesquely called the floor of the pelvis. This knowledge is a prerequisite to midwifery practice; and thus it is incumbent upon every one who essays our art as a livelihood, to obtain in the dissecting-room and the library, and not in the parturient chamber and at the expense of the patient. I do not like to appear censorious, and it certainly does not become one so fallible as myself to sit in judgment on others; but I candidly believe, from a somewhat extended knowledge of the profession gained by six years of experience as a college professor, and five years as an editor, that there are not a thousand men in America who possess the knowledge here considered requisite to the obstetrician in the practical, usable, every-day-shape indicated. For it must be understood that I do not mean mere undigested anatomical knowledge, but that intimate understanding of the philosophy of the adaptation of means to end that enables the accoucheur to take advantage of every circumstance that arises, and that can be made to tell in his patient's favor.

Now the thing which impresses itself very strongly on my mind is this, that the forces which have molded the human body into what it is, have produced the best results obtainable under the circumstances. By that I do not mean that the human body is perfect, for we know it is not. It has inherited from the forms out of which it has grown various imperfections which militate very decidedly against its complete adaptiveness to the work we require of it. Embryology is eloquent in furnishing evidence that the ancestors of the human race were aquatic in their habits, and that many structural peculiarities in man result from the transformation of an aquatic into a terrestrial animal.

But these parts, which make for disease are, in the main vestigial ones, like the pineal eye, or that section of the intestine which has been turned into a central support of the spinal cord. The parts which have been adapted to use answer perfectly to the use to which they have been adapted. If they had been specially created by Divine fiat they could not more completely serve our purpose. The human hand, as is convincingly shown in the embryo, is but a developed fin, which through countless ages of evolutionary adaption has grown at last to be the ready agent of our thought. The delicacy of the human hand compared with the clumsiness of the horse's hoof lucidly illustrates how the forces of nature adapt a part to the office it is called upon to fill; for from the same root both these grew.

The human perinæum has in like manner been adapted to this office. It, for unnumbered thousands of years, has been doing certain kinds of work; and it has learned how to do that work. It is by no means a fanciful idea that there resides in each part of the body a certain individual intelligence. The intelligence of those little beings, miscalled cells, which make up the different parts of the body, as, for instance, the perinæum, may not, and indeed is not, equal to the sum of intelligence which would have been possessed by them if they had retained their individualism, and continued as amœba-like creatures. In becoming organized into a community they lose their freedom, and their power of individual expression. But slaves think, even when chained together and worked like some huge machine. And so, though merged into tissue, these little creatures remain living beings, with an appreciable psychical life, with capacity for modification as a community according to the demands made upon them, and so adapting themselves to the exigencies of the case. The philosophy of the physiological action and power of adaptation of the perinæum will be readily understood if this idea be kept clearly in view.

It was then after this evolutionary manner that woman has come to have a perinæum which is capable of doing a certain amount of work without injury to itself; and it was not until a class of men arose who call themselves gynæcologists, that it was even suspected by women themselves what an unstable and irrational thing a perinæum is. Our grandmothers had children by the dozen, and knew not the advantages of perinæorrhaphy under antiseptic procedure. Any woman now living is the descendant of a long ancestry of women all of whom have been mothers. Her organs of generation have been adapted, by long process of generation, to the purpose of generation; and there is no more occasion for their being injured in the perform-

ance of their natural duties, than there is for the male organs of generation to be injured in the performance of their natural duties. The law of the survival of the fittest is not a law of the whole organism only, but of its various organs also. The extinct animal forms, such as the mammoth, or the hipparion, suffered and died out because their organs could not adapt themselves to changing environment. In the broadest sense those women become mothers who are most fitted to become such. And any variation in a type of woman which prevented them from assuming the ordeal of motherhood without detriment, would cause that type, or racial variety, to disappear under the well-known law of aggregation of the effect of a deteriorating tendency. If there were inherent tendencies in women to have perinæi which could not perform their duties, either those tendencies would gradually be eliminated and a more useful form of perinæum come into existence, or women would become more and more liable to imperfect perinæi, and would consequently cease to exist. For race perpetuation depends upon the perfection of the sexual organs; a type of animal whose sexual organs gradually become incapable of doing their work will die out. Man may become, as time goes on, a bald-headed and toothless race, because hair and teeth, though ornamental and useful, are not essential parts of his organism, but deterioration in the sexual function implies rapid disappearance from off the face of the earth. We realize, however, that man is not disappearing, but is increasing in numbers, and this in spite of many sexual sins which tend to prevent conception and to cause the destruction of the unborn. It is then evident that the perinæum is on the whole doing its duty, and it only remains for us to do our duty by it.

My contention is this; laceration of the perinæum should be of very rare occurrence. It is a contradiction of all we know in regard to the processes of nature to claim that she cannot make a perinæum that is able to stand the stress and strain which any natural use can put upon it. Labor being a physiological process and a basic element in the problem of the continued existence of the species, it would be folly to assert that the necessary organs were not developed in a way to secure their possessing the physiological functions for which they were created. I do not doubt perinæi rupture; but I do doubt the frequent necessity thereof. That there are men who claim, and are known to claim falsely, to have enjoyed a large obstetrical practice for years without ever having a perinæum lacerate, does not militate against the fact that perinæi ought not to lacerate. I am speaking not of the results that are, but what ought to be. And to assert, as one writer has recently

done, that "the obstetrician who knows how to diagnose laceration of all degrees, and repairs or causes them to be repaired, is not remiss in his duty," is to set up a very low standard, and in my opinion a discreditable one.

I plant my argument firmly on the basis of evolutionary necessity. It is evident that parts which have had constant necessity to adapt themselves to use during the thousands of years have not been made through that use on so insecure a plan as to break down in a large proportion of cases. If rupture occurs it is the result of mismanagement somehow. The accoucheur may not be to blame, but some one is; perhaps the woman herself. The medical man who has had the supervision of a case for months before the confinement, and the profession should make their moral influence felt in the community to the extent that it shall become a matter of course that cases are thus supervised, and then has a laceration of the perinæum, when neither mother nor babe is markedly deformed or disproportioned, must have a tough conscience unless he feels that he deserves censure. The easy-going optimism which permits laceration, because it is such "good form" to be able to do perinæorrhaphy neatly, and neatness means frequent opportunity for experience, is, to speak moderately, misplaced. The recent graduate rather prides himself on the number of his "interesting" cases. He has sat on the benches and seen the professors of obstetrics and gynæcology and surgery operate with *éclat* on the cadaver and the living subject until "complications" have no terrors for him. I had occasion, in my editorial capacity, to interview a young practitioner recently who had reported a case of vaginal thrombus during labor. The management of the case was, from a surgical point of view, unexceptionable. But the man who does midwifery practice should be an obstetrician. The more he is an obstetrician, and the less he is a surgeon, the better for his patient. In this case, the paper which had been read struck me as such an apt illustration of "how not to do it," that I desired to publish it, believing that it would carry its own proper lesson to the readers of the *Journal of Obstetrics*. But my young man hesitated. He was not sure he wanted to print the report of only one case, but would prefer to wait until he had some others! It is ordinary human experience for a person to find that for which he is looking. The man who is expecting to find thrombi in the vaginæ of the parturient, will have use, alas, for his bistoury.

It would be a sign of healthy growth in scientific midwifery if our young men were taught by the professors of obstetrics in our colleges that they ought to be ashamed of themselves if any of those so-called

"accidents" are many times repeated in their practice. It is well for the young man to be taught how to stitch up a laceration, but it is better for him to learn how to prevent one. A young man of some thirty-one summers, who graduated a few days ago from the New York Homœopathic Medical College, said to me about six weeks before his graduation, that he had had one case of labor to attend. In that case the perinæum had been completely torn through, but said he, "I learned more from that case than I would if everything had gone right, for I saw how the professors stitched it up." Not so, young man; you failed to learn how to prevent such accidents and that is a far higher kind of knowledge than the ability to deftly use a needle on quivering and bleeding flesh.

It has come to this, that our young men go out into practice with the idea that laceration of the perinæum is a very common thing; that it is naturally to be expected in one out of every three cases; and if it occurs oftener than that, well, it does not much matter, for perinæorrhaphy will set it all right, and a fellow must have cases in order to get experience. Indeed, even the laity have heard so much about lacerations that women are beginning to feel that they are somehow defrauded of their inalienable rights if the doctor does not put in a stitch or two. I had this illustrated to me this very day. About three weeks ago I confined a primipara, whom I had under preparatory treatment for four months. The fœtal position O. D. P. The first stage lasted five hours; the second, two hours; the third, ten minutes. By manipulation through the anus, and slowly shelling the head out between the pains, I got that baby delivered without even a nick of the fourchette. The case was in an apartment house where five other children (none of them my cases) had been born within a few months. When the time came for visitors the new-made mothers came, one by one, to call on the newest one. Each had the question to ask, "How many stitches did the doctor put in?" "None! why my doctor put in" three, or five, or eight, as the case might be. Each of the five had been lacerated, under the wise care of five individual doctors, and each of the five had been stitched up. Now do not misunderstand me as deprecating the "stitch or two." I always put them in myself if there is a tear extending further than the fourchette. And I might just as well say right here that I aim to practice what I preach, but that my practice sometimes falls below the ideal.

There has been a great change in the attitude of the profession in regard to laceration of the perinæum within the past twenty-five years. I attended the lectures at the New York Homœopathic Medical College

in the winter of 1869–70, and I well remember the sentiment then expressed towards men who permitted that accident to occur with much frequency. It is possible that there was at that time a lack of frankness in reporting cases. That laceration occurred much oftener than the reports would seem to indicate. It is, also, doubtless true that there was a certain carelessness in making post-parturient examinations to determine the actual condition of the uterus and the perinæum at the end of the lying-in. It was taken for granted that if the woman complained of no feeling of soreness, if the lochia ceased at the usual time, and convalescence seemed fairly established, that everything was right, and the woman was allowed to go on her way rejoicing or otherwise. I am not attempting to disguise the fact that the gynæcologist has been a thorn in the side of the obstetrician, and has made us more watchful of our cases and of our reputation. The obstetrician who, a year or two after delivering a woman of her first-born, is brought face to face, in the office of his brother gynæcologist, with a wrinkled perinæum which he has left to heal of its own sweet will, and whose own sweet will it has been to heal in a puckered and disreputable manner, is not likely to forget the sensations of that "*mauvais quart d'heure.*" Trusting to time as a remedy is a poor resource when a lacerated perinæum is in evidence. This moral suasion, this fear of exposing ourselves to ridicule, which the gynæcologist has held over us has awakened in us a healthy desire to do better work. But the gynæcologist has now advanced a new idea. It is claimed that the obstetrician is incapable of properly repairing the perinæum which has ruptured before his eyes. That the wisest thing for him to do is to nurse the case along for two or three months, and then to turn it over to the gynæcologist.

The purpose of this thesis is not criticism but suggestion; and although I am compelled to denounce what seems to me erroneous tendencies in modern midwifery in regard to the management of the perinæum during and subsequent to labor, I am yet not content to stop here, but would demonstrate what I conceive to be a more reasonable and satisfactory method of procedure. I have elsewhere claimed,* and cannot too persistently repeat, that the doctor who omits to carefully watch his patient during the whole course of pregnancy is recreant to his calling. To be sure, the profession has been so negligent of their opportunity that women do not realize how much can be done for them by medicine in preparation for parturition. While it is possible that not much could be accomplished to strengthen or render elastic the

* "Commonplace Midwifery," page 15. "On the Relation of Therapeutics to Midwifery," page 10. "The First Hours of Life," page 23.

tissues of the pelvic floor by ante-parturient medication, yet it is no fanciful supposition that the causes which operate to impair the functional vitality of the pelvic viscera are not without effect on the pelvic floor. We know so little about the ultimate operations by which tissues are built up, that we ought not to attempt to draw hard and fast lines as to what may or may not be done. If we carefully study the import of all the objective, and still more carefully all the subjective, symptoms which arise during pregnancy, and apply the similimum, we will greatly reduce the chances of disaster during parturition. The real reason of lacerations, and other "accidents," is that the woman is not prepared for the ordeal as she ought to be. There are comparatively few doctors who consider this a matter of much importance. They may have a vague idea that perhaps something might be done to help matters along, and give in a routine way pulsatilla or cimicifuga as a preparation for parturition. But this is not at all what I mean. Pulsatilla or cimicifuga are not indicated in all cases, or even in a majority of them. The pregnant condition is a physiological one, and if the woman was perfectly healthy no medication would be needed. But where is the perfectly healthy human being?

Fortunately during pregnancy women are very suceptible to the action of remedies; and conditions which make for disease also show themselves now, in evanescent and subtle ways, as if to invite attention and rectification. There is no time in the life of woman when the family doctor can do so much for her, to undo the mischief of inheritance and to make her the fit mother of a sturdy race. It is rarely that the family physician lives up to his opportunity. He cannot if he assumes too extended a practice; the best work is not consistent with money-getting; and the man who aims to make all the money he can will not find time for thankless work such as is here indicated. Besides this, he must have what is really a rare combination of knowledge, the broadest understanding of general pathology, and an equally comprehensive knowledge of the materia medicia, and deftness in fitting the remedy to the case. Not that he is to apply his remedies along pathological lines; he will not do much for his patient if he attempts that. But unless he has an intelligent and comprehensive knowledge of general pathology he will not appreciate the meaning of evanescent symptoms. When he knows what he has to treat then he should treat it homœopathically; and the Organon is his sufficient guide.

Having then brought his patient to bed in the best possible condition, his work is more than well begun, it is already half done. His

dependence may now be, as mine is,—on lard. Lard is the friend of the perinæum, and the more unnatural the condition of the perinæum the more it will do for it. I learned what lard would do for a heated and irritated tissue many years ago, in using it as a local application in erysipelas, where it not only allays local irritation, but calms nervous erythism, and reduces the systemic temperature. Finding its action so genial in a cutaneous disorder, I tried it in dry and heated vaginæ, and found that here, too, it not only acted locally as a lubricant, but that the tissues sucked it up greedily, and seemed to incorporate it, giving to them an elasticity which nothing else does. No other form of grease—vaseline, lanolin, etc.,—can replace lard. Its power of penetrating tissue, especially morbidly irritated tissue, is really wonderful. It also has here, as in erysipelas, the power of calming the nerves and preventing that rise of temperature which comes from worry and excitement. The woman will say, "Oh, how nice that feels," and her face loses that expression of extreme distress, and she bears her pains better. I never, however, use the ordinary lard of commerce, as it is not prepared with sufficient cleanliness; but have four or five pounds of leaf lard tried out and kept on hand for the occasion. Used in the form of little nuggets, from the size of an almond to a pullet's egg, introduced high into the vagina, and slowly and gently but persistently rubbed into the tissues, it will break down the rigidity of the most obstinate perinæum and prevent rupture. This furnishes a sufficient occupation for the doctor during the first stage of labor. The doctor who sits out in the dining-room smoking and telling funny stories to *paterfamilias*, or regaling himself with beef and ale, will probably have a lacerated perinæum to repair; but he who takes care of the perinæum in advance will have little use for the needle afterwards. It is commonly supposed that the doctor's presence is not needed during the first stage of labor, but he can make himself as useful then as he knows how to be. His presence in the sick-room will be an annoyance or a pleasure to the patient in just proportion to his adaptability to midwifery work. And during the first stage is the time to rectify malpositions, and to prevent the occurrence of many minor difficulties that are apt to arise in unwatched cases.

It is the doctor's duty to support his wife, but not the perinæum; it is able to support itself; that is what it was made for, and give it a fair chance and it will do it. And a fair chance consists in properly preparing the woman for childbed, and so controlling the downward thrust of the fœtal head that no undue strain is put upon the perinæum;

but it will stand without rupture a surprising amount of distention if rendered elastic by inunctions of lard, as already described. To be of real service at this critical moment the obstetrician must have such complete knowledge of the whole mechanism of labor as to do the right thing promptly and automatically. The experienced man knows that the inspiration is born of the emergency. Every case is a law unto itself. The man who works along predetermined lines, and manages his cases after certain set rules, will never achieve the best results. There is no department of medical practice where plain common sense is more helpful than in midwifery.

This address, already too far extended, necessarily leaves many points in this discussion untouched. The relation of the forceps to the perinæum and the selection of the proper forceps, might well claim attention; these are important topics. The various conditions of the perinæum, an undue muscular development, making it firm and unyielding, or the antithesis of this, a pelvic floor so soft and yielding as to allow the too rapid passage of the head; and, again, varicoses, excess of adipose tissue, and other local pathological conditions. The relation of abortion, or attempts at it, to subsequent laceration would deserve attention if there were time to consider these, but I have already trespassed too much on your good nature.

Just one word in conclusion. Let us strive to develop obstetrics into what it deserves to be, a noble and ennobling art. The supreme test of the real civilization of a people is the care which it gives to its child-bearing women. It is to the credit of these United States that nowhere in the world does the gravid woman receive such chivalric courtesy as here. It is here, therefore, that we may expect to find the highest ideals of the obstetric art, and its best practice exemplified. Let us honor the memory of our mothers, and demonstrate our loyalty to womanhood, by exerting our best endeavors to make American midwifery the beacon of the world.

DISCUSSION.

L. L. DANFORTH: I have listened with interest to this (first) paper, but I cannot see why it should be entitled "The Fourth Stage of Labor." No one can gainsay the statements with regard to the necessity for inspection and proper surgical treatment of the perineal body when it is lacerated, nor can one criticise the necessity of the methods referred to and recommended for this operation, but there is no ground for calling this the fourth stage of labor.

That is the only criticism I would make on the paper.

DR. BOOCOCK: I would like to ask the doctor why he uses hot alcohol to wash out the patient.

DR. WINTERBURN: That is not to wash the patient. The patient is cleansed by the use of boiled water used as warm as it can be and the alcohol is used on the skin to prevent any bad effects of chill.

REPORT

OF THE

BUREAU OF MENTAL AND NERVOUS DISEASES.

"Special Therapeutics of Static Electricity," - - FRANK E. CALDWELL.
"Orificial Surgery in the Cure of Mental Diseases," - - - C. A. CHURCH.
"The Colonization of Epileptics," - - - - WM. M. BUTLER.

SPECIAL THERAPEUTICS OF STATIC ELECTRICITY.

FRANK E. CALDWELL, M. D.

BROOKLYN.

In presenting this subject to the Profession it is not my purpose to enter into the etiology of each disease to which static electricity is adapted, as that may all be obtained from any standard work upon nervous diseases, but it is my purpose, so far as I am able, to present the therapeutic and physiological effects of static electricity in such a clear, concise and practical way that its true sphere of action will be fully recognized, and that it may become more and more the great boon to suffering humanity which it may be when applied in a scientific way by a physician and not left in the unskilled hands of a mere mechanical electrician. A thorough knowledge of the human system is as necessary for the proper application of this remedy as of any other, each of the various applications and each pole having its separate and distinct physiological action.

In following upon the line of nervous diseases, for our convenience we will divide it under three heads.

1st. Diseases of the Sensory Function.

2d. Diseases of the Mental Function { 1. Intellectual and 2. Moral disorders.

3d. Diseases of the Motor Function { 1. Paralytic disorders 2. Spasmodic disorders.

I. DISEASES OF THE SENSORY FUNCTION.

Among the most important and often intractable form of this class of diseases is neuralgia. It may attack any section of the body supplied with nerves, sometimes confining itself to the origin or termination, sometimes following the course of the nerve and followed, as a rule, by periods of complete rest. Most, if not all cases, need constitutional as well as local treatment; hence I commence my treatment with the negative insulation, which is a most powerful sedative tonic to the whole system, followed by a local application of the positive electrode, selecting the electrode in accordance with the location of the pain. When the facial nerves are the ones affected, I have found the direct positive breeze to be the most efficacious in relieving the pain, likewise with the spinal centers—not only relieving the pain for the time, but its continued use has cured many cases where all forms of medication have failed. For neuralgia of the abdominal and pelvic regions and of the upper and lower extremities, the direct positive spark mild is the most efficacious. With this application I have cured many cases of sciatica, one of the most frequent and painful of this class of diseases, after the patient had exhausted all forms of medication, and applications, both external and hypodermic. The physiological action of these electrodes is not that of a mere local anæsthetic, but it relieves and finally cures the pain by reducing the congestion and irritation of the nerve and restoring it to its normal condition.

CASE I. Mr. ———, age 42, was sent to me for neuralgia of the right temporal nerve, coming on generally in the evening from the slightest mental exertion or from too much physical exercise. The pain was spasmodic in character, lasting several minutes at a time, and the agony so unendurable that he had been compelled to take morphine as the only relief. He was irritable and depressed, generally anæmic, stomach and bowels more or less affected by the quantity of morphine taken. My treatment in this case was negative insulation for eight minutes, followed by positive direct breeze from electrode for five minutes on the right temporal region. The insulation quieted him

physically and nervously, making him drowsy. The direct breeze relieved the pain at once. After each application he would sleep quietly. He improved physically; the periods of pain grew further and further apart until he was entirely cured. The treatments were at first given every day, then three times a week.

CASE II. Mrs. E———, age 40, came to me with neuralgia of the inferior maxillary nerve of the right side, for five years had suffered with the most agonizing pain and as a last resort had taken morphine after exhausting the bromides and chloral. She was a nervous wreck from the effects of the pain and the drugs she was compelled to take. The pain was spasmodic, lancinating in character, the periods varying from several minutes to hours, at which times she could not speak nor move the jaw. It was worse at night, and many a night would she pass without closing her eyes to sleep. She came to me while suffering intensely. I gave her the negative insulation for five minutes, followed by positive direct breeze from the electrode on the nerve. The relief was so immediate and complete that she fell sound asleep, sitting upon the insulated platform, and had to be awakened when the treatment was over—the same thing happening at several applications. For a time the treatment was used twice a day, then once a day; the improvement in her physical and nervous condition being simply marvelous. She is still under treatment, but will be cured if she perseveres.

CASE III. Miss ———, age 28, a teacher, came to me with the history of most violent neuralgic sick headaches—"hemicrania" worse on right side and in the occipital region. They were not periodical, but came from over exertion, either mental or physical, and were aggravated by a bright light or a heated room. During the period of headache face was much flushed and a great deal of nausea without vomiting was experienced. The extremities were cold and hands bathed with a cold sweat. I employed in this case the negative insulation ten minutes and the direct positive head-breeze on the head and occipital region for five. Her hands and feet would become warm, and using her own expression, she "felt a glow all over," and the headache would entirely disappear. This was continued three times a week until the patient was dismissed cured.

CASE IV. Mr. McW———, came to me suffering from an acute attack of lumbago and sciatica of the right limb. The pain was so severe that it was with difficulty he came to my office. I gave him negative insulation for five minutes, followed by positive direct spark over the lumbar region and down the sciatic nerve for ten minutes. Three such treatments cured him.

CASE V. Mr. T., age 50, came to me suffering with sciatica which would come first in one leg, then the other, running the whole length of the leg and spasmodic and lancinating in character. Had suffered for several years and latterly been obliged to give up his occupation, which as he was a laboring man, was very hard. He had become so weak physically that he was obliged to sit down at least twice in walking a block and his friends feared he would have paralysis. He came to me with considerable fear as he said he had once had a "shock" of electricity from a faradic battery that was so severe it drew his leg all up and made him worse. I first made an electro-diagnosis of the patient with the galvanic current to ascertain the true condition of the nerves and to see if any lesion of an incurable nature existed—diagnosed it as sciatica coming from exposure and hard work. Gave him negative insulation five minutes, positive direct spark down the spine and nerve of each limb for ten minutes,—the treatment repeated three times a week. In six weeks' time he was at his business again, and now if he has a twinge of pain I am sure to have a call.

CASE VI. Mr. P., age 60, came to me suffering from gastralgia, had always been a high liver and had been troubled in consequence with dyspepsia for a goodly number of years, at times greatly aggravated, then better; bowels greatly constipated; urine scanty, amber in color and very acid. The pain in his stomach would come spasmodically and was very violent; would double him right up, and bring great beads of perspiration out all over him. In the treatment of his case, I again used the negative insulation which as a constitutional tonic in such cases is one of the very best for the whole alimentary canal from mouth to anus, followed by positive breeze over pneumogastric nerve on each side of the neck for three minutes and direct positive spark over epigastrium and spine. The patient improved from the first treatment and now for nearly three years has remained free from the pain and nearly so from the dyspepsia, except when he is imprudent at the table. This treatment I used three times a week for nearly four months.

CASE VII. Miss ———, age 24, suffered greatly with neuralgia through right ovarian region, particularly before and during first day of the menstrual period—a local examination revealed a slight irritation and tenderness of the right ovary, other organs normal, although the menses were somewhat scanty. I treated her with positive direct sparks over the lumbar region and right ovary for about ten minutes, three times a week. After three weeks treatment she passed through her period with very little pain and the flow more nearly normal.

The second time it was normal and accompanied by no pain. Pleurodynia (intercostal) and the very severe neuralgic pain which accompanies herpes zoster I have also treated with a mild positive direct spark with great success.

We now come to the consideration of sensory paralysis or general anæsthesia of the sensory nerves, including local anæsthesia.

Miss B., age 36, a teacher came under my care with this history. Was attacked one day by a very severe pain in the frontal region of the head, it finally seeming as if something burst. She immediately became helpless and numb all over, could move with ease, but sensation was so imperfect that it was with difficulty she could get around. Was confined for several weeks to her bed when the general anæsthetic condition had passed away but the slightest physical or mental exertion would cause a very severe neuralgic headache, extending from occipital to frontal region directly through the head and renew the numbness. She could not read nor write; nor stand bright light either day or night. She was suffering when she came to me for her first treatment. I gave negative insulation five minutes, positive direct breeze on the forehead, over the head and down the spine for six minutes and she left the office free from headache; repeated this treatment three times a week for nearly two months, although she insisted at the end of two weeks, she felt "perfectly well," and she can now read, write, and do a normal amount of work.

CASE IX. Miss —, age 23, general anæsthesia of both upper and lower extremities, worse in the lower, especially so in the left leg. A pin could be stuck in almost any portion of it without pain. At times the leg would give way, and she would stumble or fall. The functions of the body were all normal and she attributed this condition to overwork and excessive nervous strain. It had existed for about eight months. In this case I employed the positive insulation for five minutes, wishing to obtain more of the effect of the stimulating tonic, and followed with the direct negative spark to arms and down the spine and legs, occupying ten minutes in this application. She felt immediate relief and was eventually entirely cured.

CASE X. Mrs.—, came to me complaining of a numbness of the first and second finger of the right hand, with tingling of the whole arm, was very annoying, especially at night, preventing her resting and was fearful of paralysis. Negative direct spark over cervical region and down the arm to extremity of fingers, repeated three times a week, cured her in a few weeks time.

Spinal irritation complicated with neuralgia is a disease that nerve specialists are meeting with more and more frequency. Since the epidemic of La Grippe, I think our cases have increased two-fold and a chapter of clinical cases might be devoted to this subject alone, with profit, but a few cases must suffice. I firmly believe that spinal irritation does exist in both anæmic and hyperæmic conditions of the cord, depending largely, in fact almost entirely, upon the cause that produced the irritation. Again the irritation may be localized to any portion of the spine or be general, involving the whole tract.

CASE XI. Miss —, came to me for treatment, having nursed her mother through a long and severe illness, followed by an attack of Grippe, herself. Her nervous break down was complete; she was generally anæmic, very nervous and irritable with shortness of breath and weak heart's action, appetite variable and digestion weak. She complained of cold spots along the spine; the cervical region felt heavy, affecting the whole back so that she wanted to rest it against something solid. At times she had erratic pains in the spine and was troubled with insomnia. I diagnosed the case as spinal anæmia. As a constitutional tonic, I used the positive insulation for ten minutes, followed by negative breeze to the spine, and the direct negative spark to the limbs to overcome the cold extremities, which is characteristic of such cases. Treatment was given three times a week. The improvement was slow but steady, and while not yet entirely well, is much improved in every respect.

CASE XII. Miss —, came to me with the history of a fall from a hammock, hurting especially the end of the spine and jarring the whole system. The neuralgic pain in the coccyx at times was very severe; it was sensitive to pressure, and the dorsal region also was more or less sensitive. Functions of the body nearly normal. As a general treatment I gave her negative insulation five minutes, followed by direct positive breeze to the spine and a mild direct spark to the coccyx for a similar time, treatment three times a week. She experienced relief at once and while not entirely well, considers herself so, as she experiences very little pain.

One of the most important spheres of action of static electricity is that upon the brain in mental diseases. In many cases of insanity even, I doubt if there is any remedial agent that would compare with it in its curative effect, if the "static" were given a fair trial. I may be rated as an enthusiast, but I should like to see every insane asylum fully equipped with electrical outfits, a first-class "static" battery

among them, and a physician in charge to administer it. I went in consultation to one of our large asylums last winter and upon inquiring what electrical appliances they had, found they were provided only with small portable galvanic and faradic batteries, and those were seldom used. I believe this to be all wrong, and that the per cent. of cures would exceed our most sanguine expectations if electricity were properly administered; and further that every institution failing so to do, is depriving its patients of one more chance to escape from a living death.

In the application of the static current to mental diseases, the positive direct breeze is the more powerful sedative tonic, the negative the reverse.

Miss —, age 22, came to me in a state of great nervous irritability, melancholia with suicidal tendency, had tried to throw herself from a window, and had to be constantly watched. At times would have violent crying spells. Physically she seemed perfectly well, every function being performed normally as far as I could judge from inquiry or examination. The condition came on suddenly after the sudden death of a brother, and her family were in great fear and distress over her.

I used in her case negative insulation for five minutes with positive direct breeze over head and down the spine for ten minutes, repeating the treatment three times a week. In three months time my patient was entirely well, her improvement dating from the first treatment.

In the treatment of brain fag of professional men, I know of no tonic so powerful and refreshing. I have had ministers come to my office exhausted by their work, tired out in mind and body, and go away feeling refreshed in every way.

Hysteria, which of all forms of nervous disease is, perhaps, the most aggravating to the physician to treat, in this form of electricity finds not only relief for the time being, but frequently a cure after everything else has failed. Generally for hysteria I give a thorough constitutional treatment, commencing with negative insulation, then positive direct breeze on head and spine, and positive direct spark on the spine, particularly over the lumbar and ovarian region. As a rule, beneficial effects are observed at once, the patient feeling stronger, brighter in spirits, looking less at herself and the attacks becoming further and further apart. Hysterical diseases are supposed to belong peculiarly to women, but it has been my lot to see men afflicted with hysteria as genuine as ever women suffered from, caused in the majority of cases by sexual excesses.

Static negative insulation with direct positive breeze on head and

spine and direct positive spark on lumbar region and genital organs has been, as a rule, the treatment which has proved the most successful.

I have exhausted my time though not my subject and must leave other clinical cases and the consideration of the affections of the motor nerves for some other occasion.

ORIFICIAL SURGERY IN THE CURE OF MENTAL DISEASE.

C. A. CHURCH, M, D.

PASSAIC, N. J.

Orificial surgery deals also with the orifices of the body, and principally with the lower ones, the rectum, bladder and sexual organs. What have these orifices to do with mental disease?

A few years ago a bare statement of this question would have carried with it an a priori answer. But the study of the so-called reflexes has opened the eyes of the profession to hitherto unknown causes of disease effects. My paper is in this line. In the consideration of my subject I wish to emphasize three points. The first is, that the pathology of insanity has not been found in the brain.

Spitzka says: "In not a single accurately studied case reported by trustworthy observers has a characteristic lesion of the essential mental apparatus been found, nor has any doubtful appearance of any kind been discovered that has not been found in lesser degree in sane persons also." And Mendel closes the discussion of this subject in the following words: "From all this I draw the conclusion that mania is a disease whose patho-anatomical basis we have thus far not been able to discover in the brain."

The second point is, that disease of the rectum, though sometimes obscure, will always be found in the insane. A student of the Woman's Medical College of Philadelphia, who dissected the perinæi of several women who had died at the Morristown Asylum, told me that it was noticed and commented upon by the students, that every one of them had dreadful disease of the rectum. Prof. Pratt of Chicago has for five years had a standing offer of one hundred dollars to anyone who will show him a case of chronic disease, mental or otherwise, without orificial pathology. Two cases which I wish to give in illustration, will still further strengthen this point and at the same time

bring out my third point, which is that insanity is curable in most cases by orificial operation.

CASE I. A lady, 62 years of age, married, mother. Had been treated successfully many years ago for ulceration of the os and cervix uteri. She was also troubled about the same time with hæmorrhoids, but not recently. For three years with two short intermissions she had been insane. There was insanity in the family a brother and a sister having both died insane, and also a son of each had died in the same mental condition. The only other member of her family, a sister, had died of gangrene of the foot from diabetes. The case was diagnosed as orificial, probably rectal, although a specialist in nervous diseases had examined the sexual organs and declared that the trouble was all in the brain. In February last an anæsthetic was administered and an orificial operation made upon her. The principal trouble, as was anticipated, was found in the rectum, the so-called hæmorrhoidal inch lying between the external and internal sphincter muscles was very badly diseased, the tissues were swollen hypertrophied and congested and looked as if they had already begun to slough. But there had been no complaint of rectal trouble for years. These diseased tissues were removed by what is known as the American or Pratt operation, to distinguish it from the English or Whitehead operation, and the patient placed in bed. She came out of the effects of the anæsthetic in her right mind and has remained so to this day; has taken her old place in her home, in society and in the church. She returned a few days ago from a short sojourn at the sea shore a healthy happy woman sound in body and mind.

This was a plain case. As soon as the diseased condition was exposed, which could only be satisfactorily done under anæsthesia, every physician present recognized the necessity for operation, the family physician declaring that it was a physical sin for any person, insane or not, to carry around such a mass of disease.

CASE II was entirely different, but in my judgment more instructive. A lady, aged about 47, married, mother of three children. Husband a strong robust man, oldest son 22 or 23 a fine specimen of physical manhood. Her second son about 16 years of age seemed to have been born with spinal disease, is mentally weak and an epileptic, a helpless burden upon the mother all these years. About two years ago a daughter was born, a beautiful child, but she too soon began to manifest the same evidences of spinal weakness, which was more than the mother could stand. She grew sad, withdrew herself from others, became morose, irritable, spiteful and finally fierce and dangerous.

I gave the opinion in the case, on general principles, that there was orificial disease, probably rectal, she was given an anæsthetic for orificial examination and operation and several sources of orificial irritation found and removed among which was a cicatricial plug at the internal os uteri. But when the rectum came to be examined it was to all appearance in a perfectly normal condition; several physicians who were present thought they had a good joke on me. As one of them put it, Church invited them to see an orificial case and had opened up before them the soundest rectum the light of the sun ever shone upon. I thought myself that for once I was left, but I was not as the sequel shows. The result of this operation was improved nutrition, the patient who was greatly emaciated gained about fifty pounds, as near as we could judge in the next few months. An albuminuria that was present at the time of the operation cleared up entirely, but the mental condition did not improve in the least, grew worse if anything. I wrote to Prof. Pratt, of Chicago, asking his opinion and advice. He strongly advised the American operation no matter what the apparent condition of the rectum; giving as his opinion that there were diseased or irritated terminal nerve fibers even though I could not see them. I waited until fully six months had passed since the first operation, with no improvement of the mental trouble, and then made the American operation. When she came out of her anæsthesia she called for a glass of milk and drank it, the first mouthful of food or drink that had passed her lips in more than six months, she having always to be fed by a tube through the nose. Several weeks after the last operation, the husband and physician wrote me, saying: "A great change has come over the patient, she has lost her fierceness, does not scratch or strike. She looks at us, talks to us, smiles occasionally, and has a natural tone of voice. She still has hallucinations, thinks some one is after her, or trying to injure her or carry her off. She knows they are hallucinations and will laugh about them afterwards." On Monday of this week I received a note from the husband in which he says: "My wife has pulled up a good deal during the past few weeks. One Sunday about seven weeks ago she called for a regular meat dinner and ate it, and from then onward has improved almost steadily. She cleans her teeth regularly, helps about her bath, and eats, drinks, and sleeps well but is not altogether free from hallucinations."

What is the explanation of this apparently healthy condition of rectum in an insane patient, and yet such marked improvement of the mental condition from the rectal operation? Those who have had most experience in orificial work, claim that in many cases of orificial

disease, as the constitutional effects of sympathetic nerve irritation become more pronounced, the local condition passes from the state of hypertrophy and congestion into one of atrophy, the terminal nerves becoming pinched by contraction instead of being swollen and sensitive from inflammation. This I believe to have been the condition in this case. That there had been serious rectal troubles in former years I have no doubt.

First. Because there had been since before the birth of her second child a train of functional diseases of the heart, lungs, and digestive organs, which in the light of present knowledge and experience I have come to recognize as pathogomonic of rectal disease.

Second. Because at the time of the second operation, with the improved nutrition which had followed the first operation there had developed hæmorrhoidal troubles.

Third. Because, as already mentioned, such favorable results followed the second operation.

Very flattering results from orificial treatment are claimed by those in position to know best, it being asserted that at least two-thirds of all cases operated upon are cured and that all are benefited.

Dr. H. P. Stiles, of Chicago, read a paper before the American Association of Orificial Surgeons at the meeting in September, in which he gave a series of cases of insanity successfully treated by orificial operation. I was informed that his success in this line had been so satisfactory that he contemplated opening an institution for that class of cases. I think nearly every number of the *Orificial Journal* has contained reports of cures of mental disease by orificial operation made by different surgeons so that this line of treatment is no longer an experiment or a question, it has become a fact of experience. The three points I have tried to establish: *First:* No pathology of the brain to be found in insanity, *Second:* Instead a pathology of the rectum, *Third:* The removal of which results in a cure, form a basis for the treatment which no more "I don't believe it" can upset.

I now pass to notice the very natural and appropriate question: What foundation has the orificial idea, aside from the results secured? Is there anything in anatomy, physiology or pathology that will uphold its claims; or is it only a crank notion? I answer, in my judgment it is founded in truth, it has come to stay. Its philosophy can be perfectly demonstrated by known laws scientifically interpreted and applied.

Let me try to give you some of its fundamental principles. There are three principles or processes in the animal economy, which are

entitled to be denominated vital, because no one of them can be arrested without death, and no one of them can be changed from the normal without lowering the standard of health. These three are peristalsis, capillary circulation and cell action.

We live in tubes. We take our food into a tube, it is digested by secretions brought to it in tubes, it is then carried into the blood by tubes, brought into contact with air in the lungs through tubes, is circulated in tubes, we breath through tubes, perspire from tubes, the scavengers of the body, the lymphatics, work through tubes, and the excretions pass out through tubes. These tubes all have two sets of muscular fibres a longitudinal and a circular, both are of nonstriated variety and under control of the sympathetic nerve. The alternate contraction of these muscular fibres is peristaltic action. While we live in tubes we live by capillary circulation and cell action, the process of nutrition being dependent upon both. All of these processes, indeed all the organic processes of the body, are controlled by the sympathetic nerve.

The sympathetic nerve is the woman of the house. She attends to the sweeping, cleaning and keeping the house in order. She looks after the cooking and serving of our food. Sees that the house is kept in good repair. Notifies the man of the house when the larder gets empty or the well dries up. She works while he sleeps and when he wakes, while he works and when he plays. She never sleeps, never complains, never takes a vacation. When the woman of the house is tired or sick or off duty for any cause, things go to ruin fast. In one thing this woman of the house seems to lack intelligence and discrimination. She will work just as hard to expel her own membrane if it is a little sick as she will to expel a foreign body. Familiar examples of this are the tenesmus of cystitis and dysentery. To overcome these expulsive efforts, the sphincter muscles are obliged to shut down hard and tight. The result of this antagonism between the expulsive efforts and the contracted sphincter is two-fold, it exhausts nerve force and it pinches terminal nerve fibres.

The lower orifices of the body are terminal sympathetic nerve centers. This is easily demonstrated, put a patient with irritable rectum into a condition of profound anæsthesia, so profound that you can cut them or crush them or do anything you choose and they will manifest no sign. Now grasp an irritable hæmorrhoid or any of the irritable tissues of the hæmorrhoidal inch with forceps, and the sympathetic nerve system will fairly cry out in agony and alarm. We are sometimes obliged to remove the forceps from these tissues during an

operation because of the alarming effects produced upon the respiration. Patients have died from the effect of ligaturing a hæmorrhoid because the surgeon did not understand this fact and remove the ligature. Now introduce a rectal speculum and you can play with the patient's life as a cat plays with a mouse. You can stop his breath or let him breathe as you choose. With this same rectal speculum you can flush the entire capillary system of the body. You can resuscitate the asphyxiated from drowning, the narcotised with opium, the drunken with alcohol or arrested respiration from anæsthesia.

Orificial surgeons are taking advantage of these facts. This knowledge and proper instruments should be in the possession of every practitioner. Anæsthetics should never be given without a rectal speculum conveniently at hand in case of accident or emergency. It is worth a thousand times more than the battery or artificial respiration or hypodermic injection or any previously known method of resuscitation.

If irritation of the terminal nerve fibers of the cerebro-spinal system at the bottom of the foot can derange the entire voluntary muscular system of the body even to the extent of tetanic convulsions, is it to be supposed an irritation of the sensitive terminal nerves of the sympathetic system or the constant pinching of them by contracted sphincters continued for months and years can be otherwise than seriously embarrassing to the vital processes whose action depends upon the force and integrity of this system of nerves?

Orificial surgery is simply a method or means of removing irritations from these terminal nerves, and dilating sphincters which pinch them, and thereby restoring normal peristalsis strengthening capillary circulation and regulating cell action. Can you conceive a condition of chronic mental disease or any other that would not be improved by such a process?

DISCUSSION.

PRESIDENT FISKE: Those of us who have a pair of healthy thumbs need not fear administering anæsthetics without other apparatus for stretching the sphincter ani.

B. G. CLARK: So far back as 1860 Dr. Emmet cured convulsions and other reflex troubles by cutting out cicatrices from the cervix; a forerunner of the orificial surgery of to-day.

THE COLONIZATION OF EPILEPTICS.

W. M. BUTLER, A. M., M. D.,

BROOKLYN.

Epilepsy has ever been and still remains the *bête noir* of the medical profession. After years of laborious pathological research, and extensive clinical experimentation, it still, to day, bids defiance to medical science, and by its ravages yearly swells the ranks of the hopelessly incurable, who, during life, remain the recipients of state and county care.

In New York state alone one thousand are incarcerated in our State hospitals for the insane, and the whole number in the United States is estimated at no less than one hundred and twenty thousand. Although so formidable, as to numbers, the epileptic occupies a peculiar position in society. Debarred from school, church and general amusements, shunned by his companions, unable to obtain employment, he is practically in a state of perpetual quarantine, as to the rest of mankind. Thus far the only places of refuge have been in the almshouse and lunatic asylum. These cases should certainly not be kept in our hospitals for the insane, as many of these are not virtually insane, being only subject to paroxysms of excitement at the time of their convulsive seizures, and in the intervals retain the entire possession of their mental faculties. Nor is the presence of the epileptic less disturbing to the proper inmates of the wards. I am certain that I voice the sentiment of every superintendent of the insane when I most emphatically assert that the insane and epileptic ought not to be housed together. Thus far the matter has been one of compulsion rather than choice, as the epileptic could not be allowed in ordinary hospitals, and it was thought that he would do less harm among the insane than elsewhere. A large proportion of epileptics are, moreover, never insane, and, except during the short intervals of their seizures, are capable of pursuing the ordinary vocations of life. Still the nature of their malady raises an impassible barrier to their admission into ordinary channels of business. Certainly some other provision should be made for this class of unfortunates. This necessity becomes daily more and more urgent, since the present policy of state care of all the pauper insane are crowding the wards of all insane hospitals to overflowing, and they should not be burdened by

a thousand inmates that do not belong there. The question then arises what shall we do with our epileptics? Nor does this question merely include the provision for a place of seclusion and protection for the sufferer, it embraces much more. Our care should be educational as well as medical. Not only should the best medical skill be exerted for his restoration to health, but the epileptic should be educated and trained in different pursuits, thus rendering him capable of earning a livelihood.

This seems only possible of attainment by the formation of epileptic colonies. Such a colony should contain schools, churches, places of amusement, workshops, stores, gardens and hospitals—in fact be a perfect little world by itself.

Nor is this a mere Utopian scheme. For years have epileptic colonies been in successful operation in different countries of Europe. They were first conceived by a philanthropic Lutheran clergyman, Pastor Von Bodelschwingh, who nearly thirty years ago started with four patients the now noted colony of Bielefeld, in Hanover, Germany. Increasing and expanding from year to year his original colony of four in 1892 contains over twelve hundred patients. During twenty years, from 1867 to 1887, 2407 epileptics received treatment at this colony, of whom 156, or 6½ per cent., were discharged recovered and over 450 improved. Here by degrees has been evolved an almost perfect curative and educational establishment where every variety of handicraft is taught and the patients are surrounded by everything which can elevate and improve their mental and physical condition. Numerous houses and cottages, scattered in pretty gardens over three hundred and twenty acres of beautiful woodland and meadow, form a veritable Eldorado for the victims of this fell disorder. Modeled after Bielefeld, Germany has established nine epileptic colonies, Holland one, Switzerland one, and one has also been erected by private enterprise in France. Nor has the success of these colonies been without effect upon the United States. Already have establishments patterned upon the same plan been founded and are now in operation in Gallipolis, Ohio, and at Santa Clara, California. Pennsylvania and Massachusetts have also taken active steps looking to the same results.

The New York State Legislature passed a law during its last session, which has gone into effect, giving power to the State Board of Charities to choose a site and prepare plans for the founding of a similar institution in New York State.

The following is the text of the law in question:

Hospitals for Epileptics. Chapter 503 of the Laws of 1892. An

Act providing for the appointment of a Commission to locate an Institution for Epileptics in the State of New York.

The People of the State of New York represented in Senate and Assembly do enact as follows:

Section 1. The Commissioners of the State Board of Charities are hereby directed to select a suitable site in the State of New York, on which to establish an institution on the colony plan for the medical treatment, care, education and employment of epileptics.

Section 2. The said Commissioners of the State Board of Charities shall have power to receive by gift or to contract for the purchase of such site for the location of buildings of said institution, subject, however, to the approval of the next Legislature, to whom they shall report their action in the premises within ten days after commencement of the session, together with plans and estimates for constructing buildings suitable for the purpose, named in section one of this Act; such site to include not less than three hundred acres and such plans to provide for the accommodation of six hundred inmates and to admit such further extension of the buildings as may be necessary to meet further requirements of the State in providing for the epileptics.

Section 3. The said Commissioners shall be entitled to the payment of their traveling expenses while engaged in the performance of their duties under this act, and their account for such expenses shall be audited and paid out of the treasury, but they shall receive no compensation for their services. And the sum of one thousand five hundred dollars, or so much thereof as may be necessary, is hereby appropriated out of any moneys in the treasury not otherwise appropriated, payable on the warrant of the Comptroller for the purpose of this act. This act shall take effect immediately.

In view of the imperative needs of the epileptic and the public interest which has been already manifested in the subject, we have thought it worthy of presentation to you as members of the N. Y. State Hom. Society, at this time. Any influence which you, as physicians, can exert upon the members of the next Legislature which shall help to bring about this most laudable result it seems to us would be well expended.

When the United States shall be dotted over with epileptic colonies, similar to Bielefeld, much certainly can be done towards the betterment of the epileptic's condition and the development of all his faculties, even if the disease itself is not entirely eradicated.

REPORT

OF THE

BUREAU OF LARYNGOLOGY AND RHINOLOGY.

"Diphtheria," - - - - - - - - J. B. GARRISON.
"Rational Treatment of the Throat and Nose," - - LOUIS A. BULL.
"Some Suggestions on Adenoid Growths in the Naso-Pharyngeal Space," - - - - J. M. SCHLEY.
"Ulcerative Rhinitis following Diphtheria," - - M. W. VANDENBURG.
"Treatment of Hypertrophic Rhinitis," - - - C. E. TEETS.
"Syphilis of the Mouth and Throat with Treatment," - - - - - - - - H. WORTHINGTON PAIGE.

DIPHTHERIA.

J. B. GARRISON, M. D.,

NEW YORK.

Aræteus of Cappadocia was probably the first to give a good description of the disease, and he termed it "Syriac ulcer." Bullonius of Paris was the first to speak of the false membrane, in 1576. Peter Forestrius, 1557, Von Woerd (Holland), Joannes Wierus (Dantzig), Coligni (Augsburg), 1565—all speak of epidemics which were probably diphtheritic. It was first noticed and spoken of in America in the seventeenth century. Bretonneau in 1821 wrote a paper describing it, in which he claimed identity with membranous croup. He claimed also that it was a purely local disease. This point has long been discussed, but it seems to be settled that it is highly probable that it is excited by some form of bacterium.

That it is highly contagious seems to admit of no doubt. The methods of transmission most usual are a polluted water supply, bad drainage, milk of diseased cows, clothing previously infected and then exposed in the presence of the victim, and dogs, cats, and even birds, as pigeons, are said to have been the means of conveyance.

The ordinary cases I shall not speak of, but there is a class that I am especially interested in, and one that I have learned to have great respect for, and I beg to note two or three cases that have come under my notice.

CASE I. Lillie J., æt. eleven, came home from school at noon complaining of a severe headache; had been well in the morning. I saw her early in the evening, and found her with flushed face, restless, temperature 99 4-5°, pulse 100, some pain on swallowing, tonsils very slightly changed in color, and only, slightly if any, larger than they were accustomed to be, and a very small point of exudation on one of them—I forget which now. My cases of diphtheria had all of them had a high temperature previously, and I left her thinking it was to be a light case. The next day the temperature rose to a trifle over 100°, and the patch spread over a large surface. The pain in swallowing was only slight and the appetite was fair. But the patch became still larger, and the other tonsil became affected, and the third day the temperature was 101°, and the tonsils looked as if they were covered with pieces of wet chamois skin, which adhered tightly to the surfaces of the glands. I was also worried when I noticed a hoarseness, and on my second visit at noon I found it had increased, and told the family that I feared there was more danger than I had at first anticipated, and suggested a consultation. Professor C. E. Beebe was sent for and met me at the bedside in the evening, when he at once refused to operate and gave a most unfavorable prognosis. She died on the fifth day, lying in a comatose condition for about two hours previously.

CASE II. Paul S., æt. five, complained of being sick after breakfast, and I saw him about ten o'clock. Was playing on the floor; said his throat was sore. Temperature 100°, and small, white patch on left tonsil. The mother said she did not think he was very sick, but thought best to send for a doctor before there was any danger. I allowed her to see the throat, and told her that although there was very little swelling and not much of a patch, I believed there was a great deal of danger, and told her I feared it more than if it looked much worse. The temperature never ran above 101°, but the membrane spread, assuming the same general appearances described in Case 1. On the fourth day the disease invaded the larynx, and on the fifth I intubated, with only partial relief, and on the sixth day he died.

These cases were the first and last cases of the kind I saw, and I would like to know if others have had in their practice cases of the same character with as high a rate of mortality.

In the first case there were no other children, but in the last one

there was a younger brother who, despite all my protests, was allowed to come into the room where the sick child was at will. To him I gave apis 3 several times a day as a prophylactic and he escaped entirely.

For several years I have made it a rule to administer apis to the well children of the family when a diphtheritic case came under my care, and in no instance have I had a second case where I have prescribed it. Isolation and disinfection I believe to be absolutely necessary, and always insist on their being carried out, but in some cases the isolation at least is about impossible.

The treatment in my opinion should be by internal medication; local swabbing, scrubbing, only irritating the patient and not reaching the seat of the poison. The use of H_2O_2 in the form of a spray has seemed beneficial, and is so mild that all will submit to it, and I frequently use it. Hygiene must be carefully attended to and the strength kept up by every means possible. *Perfect rest* must be insisted upon, and that too after the membrane has disappeared entirely.

RATIONAL TREATMENT OF THE THROAT AND NOSE.

LOUIS A. BULL, M. D.,

BUFFALO.

The old German proverb has it "The middle course is best." It teaches us to "find sermons in books and good in everything" whether this be the potency of the Hahnemannian, the material treatment of our old school friends, or a judicious admixture of both. As to the necessity of taking this view of the case in treatment of the throat and nose, the following cases will, I think, bear witness:

Mr.———æt 45, quite typically asthmatic in appearance, came to me for relief from a terrible cough. He gave the following history: Never very rugged yet seldom sick; had the grip two years before, and during a paroxysm of coughing (so he was told by competent medical advice) had broken a blood-vessel in the upper and inner portion of the infra-clavicular region. The peculiar cough which he desired to be rid of followed shortly after this. It is impossible to describe the sound of it, but it was very explosive in its beginning and was a gradual decrescendo until the lungs were emptied, when it was

followed by spasm of the glottis. He would then turn blue in the face and sometimes become unconcious. The lungs were somewhat emphysematous with dullness in the infra-clavicular region, and the membrane lining the nose and throat was relaxed and chronically congested. He had been prescribed for homœopathically and then treated some time by an old school laryngologist. The latter finally sent him away, saying that nothing could be done unless the chest was opened and the left recurrent laryngeal nerve freed from its irritating sur roundings. He was unwilling to undergo an operation which would not surely promise a cure, so he drifted into my office. The circumstances were quite sufficient to stimulate one; so while he received treatment locally with the end in view of toning up the relaxed membranes, he was carefully studied from a therapeutic standpoint and finally given apis, with the very satisfactory result of relieving this spasmodic cough. I saw little of him after this. He was one of those rare birds who always pay cash, and as he had spent most of his money on my predecessors, declined to go into debt and also felt that by proper diet, &c., he would finally get well. My other case is the opposite of this.

Miss———, æt. 18, tall, thin, excessively nervous, any little excitement bringing on twitching all over the body and being accompanied with floods of tears. Her menstruation was irregular; had a voracious appetite for lean meat, slept badly and altogether was the despair of her mother. The nose, which was narrow was filled (both sides) with hard gray-green crusts which formed on the three turbinateds and also on the septum. These were not fetid though very disagreeable in odor. The vault of the pharnyx had its coating and some crusts formed on the posterior wall, which was dry and glistening and showed the vertebræ plainly beneath the membrane. This young woman had received most excellent homœopathic prescriptions but was plainly growing progressively worse. Treatment was begun by cleansing the nose and throat with a warm solution of sodae bi-carb. applied through the post-nasal syringe. Then the crusts which this did not reach were removed by the cotton-covered probe saturated with glycerine (a most excellent suggestion of Prof. Ivins, of Philadelphia). Then followed the covering of the cleansed membranes with plantago oil. Internally she was given pulsatilla. Under this regime she began to improve and so continued until her discharge.

These two cases illustrate the point I would make, strict individualization and a mind open to the good points of every system of practice. The former needing no local treatment and the latter absolutely depending upon it.

SOME SUGGESTIONS ON ADENOID GROWTHS IN THE NASO-PHLARYNGEAL SPACE.

J. M. SCHLEY, M. D.,

NEW YORK.

To the physician who is a close observer and student of medical literature, covering all or most of the specialties of medicine or to the specialist himself, the remarks I have to make may seem trite, but, to some of us in general practice the lesson may bring forth its fruit.

Since Türck and Voltolini's announcement of the intimate relations, reflex if you wish, between the nose and pharynx and the thoracic organs, the latter demanding a free and unobstructed passage way from the former for a perfect carrying out of its normal work—a great deal has been written. Some of this literature it is true, has been written by over zealous and enthusiastic specialists and has shown such remarkable results in relieving the patient or patients of their sufferings, that in most part it has fallen on unwilling and unbelieving ears.

Then again the acceptance of these facts—for such they have come to be every day of the year—would make serious inroads into the general practitioner's work and oftentimes upset a pet theory or his diagnosis in a given case much to his discomfiture. If we commence with a baby or child, suffering from adenoid hypertrophy, what are the symptoms which we are most likely to meet?

From my own personal observations in such cases we almost invariably find accompanying our subject under discussion either an hypertrophic rhinitis, a deflection of the septum, cartilaginous or bony, a granular pharyngitis or enlarged tonsils. Each one of these morbid conditions plays a role singly or collectively in augmenting the patient's discomfort. I would *betone* these complications as they should be dealt with therapeutically or surgically at the same time or independantly of the removal of the adenoid growths. We note in the baby a restless sleep, mouth open, becoming parched, causing the child to start up suddenly with a smacking of the lips, a readiness to recurrent attacks of rhinitis which prove very obstinate to all kinds of treatment, a marked tendency to acute and sub-acute inflammations of the middle-ear, a disposition to catarrhal laryngitis, laryngismus

stridulus (as a reflex condition), a dry persistent cough (reflex), enuresis (?), asthmatic conditions, etc.

These are some of the symptoms and conditions noticed, and there are doubtless others which may have attracted the attention of individual observers who have placed their own value upon them. The voice is often more or less affected, causing a nasal tone to its timbre or producing a sense of the patient having something soft in his mouth in trying to articulate. Sometimes the restlessness of the child at night, his peevishness, tantrums, uncertain appetite, gritting of his teeth and other symptoms which make up the *worm picture* may be present. Again if the sufferer be a boy, symptoms pointing to his urinary organs may come forward most prominently, demanding circumcision or other local investigations. After anti-worm medicines, and circumcision have been tried, we not infrequently find our patient in about the same condition as before.

If we meet with a child five or six years of age with marked adenoid hypertrophy, his symptoms will not vary much from those just mentioned. He may be able to locate his difficulty, however, more pointedly. At his age a clearing of the throat, dropping of mucus from the vault of pharynx, nasal tone to voice, etc., show out more prominently.

I am of the opinion that these adenoid vegetations are liable to take on an acute inflammatory state akin to follicular tonsillitis, and that many slight fevers with severe headaches and uncertain throat distress may arise from such an obscure yet tangible cause.

It is at this age and a little later that serious chronic nasal and pharyngeal troubles gradually develope, and which further along, defy all our remedial measures, especially if the middle ear has become involved.

From six years onwards the march of the disease and its symptoms, (symptomatic and objective) keep apace.

It is well established that all these adenoid hypertrophies tend to decrease and disappear by a certain age in a man's life, and if they do not atrophy they pass into an inert and semi-harmless state. I I have seen large adenoid growths quite disappear after being under observation many years before the patient had reached twenty-four.

In England it is quite the fashion for all practitioners paying any attention to the throat to direct their attention among the young especially to this part of the respiratory tract. In fact many are so intent upon this one point, that they quite overlook or underestimate an hypertrophic rhinitis, and hypertrophied tonsils. If then, many conservative men of prominence have come to realize the importance this part of our anatomy plays, when its parts become diseased, it seems

to me we should at least take cognizance of this growing and important fact.

It is not necessary for a physician to be in any way a specialist to cope with this trivial malady when once diagnosed. A safe protection to his finger and the rapid passing of the same up behind the soft palate well up into the pharynx will speedily tell him by the soft velvety, raspberry feel, that he meets with a foreign body, though it often happens that the growth is large and quite hard and situated high up. When these masses are large and stick well out into the free space of the vault, they diminish the opening to the posterior nares in ratio to their size and certainly prevent in all cases the onward flow of air into the lower pharynx. Therefore, in children I would take it as a wise axiom where a rhinoscopic picture cannot be obtained, to examine the vault carefully with or without an anæsthetic as the case may demand. The finger (index) is the safest and most reliable instrument you can employ for diagnostic and operating purposes.

I should like briefly to speak of three cases which cover the field of symptoms pretty well.

A young lad seven years of age was brought to me from Pittsburgh for diagnosis, and if possible to relieve a continuous dry cough reaching at times an asthmatic state. His father was severely asthmatic. On physical examination I found no heart lesion and simply harsh breathing over both lungs, indicating congestion of the bronchia. His tonsils had been amputated, his nose relieved of redundant tissue, still this persistent cough necessitating his being propped up at night with pillows, and during the day it had been one continuous hack for months. Luschka's tonsil was found much enlarged ; it was removed entirely in four sittings and in a week's time patient ceased coughing in toto and has remained well since then. His general health I was told the other day was vastly better than it ever had been before. He had no symptoms pointing to his throat. Here all kinds of medication including opiates had been fairly tried.

A second case was a lad 12 years of age. He had hypertrophic rhinitis, enlarged third tonsil, and enlarged faucial tonsils. His complaints were frequent and severe head colds with muco-purulent and purulent discharges, frontal and temple headaches, dropping of mucus, constant desire to dislodge something from back of his throat, stuffiness in ears, repeated tonsilitis and often a dry, obstinate cough. Luschka's tonsil was removed at one sitting, his tonsils at another, and the hypertrophied membrane of the nose after many applications of the cautery. The patient seen months after the last operation was

quite free of all catarrhal symptoms. Homœopathic treatment in this case had been utterly useless after many months trial.

A young lady in a neighboring convent was brought to me for impaired voice, gradual loss of hearing, occasional paroxysmal coughing which was always dry and mostly at night. Examination showed a slight rhinitis hypertrophica, an enormously enlarged Luschka's tonsil, granular pharynx and faucial tonsils not sufficiently enlarged to require amputation. I have never seen such a continuous, uniform enlargement of adenoid growth in the vault. It was removed with the curette. All her symptoms improved immediately save her hearing which remained as it was. Her singing voice was better than ever before. None of these cases required the administration of an anæsthetic. In very young and refractory children ether or chloroform seems to be a necessity.

I would suggest then, that:

I. In obscure cases in children all the organs be interrogated; that,

II. If a careful physical examination has proved nothing, for us to hunt further and not be satisfied until we have found the offending organ;

III. It is time for us to cease being satisfied with an array of important or unimportant symptoms to base our *diagnosis* and *treatment* upon, for

IV. Such cases are *not curable* save by operation up to a given age.

V. The operation—if it rises to the dignity of such a term in such cases—can be performed by any qualified practitioner of medicine.

VI. It should be done thoroughly and completely.

VII. In children an anæsthetic is most advisable.

VIII. The benefits to accrue from such an operation can only be appreciated from personal observation.

IX. The necessary instruments are a mouth-gag, your fingers and a suitable set of pharyngeal curettes.

DISCUSSION.

L. A. BULL: I would like to ask Dr. Schley if he has had any experience with the symptom of irritation at the back of the neck, patients rub the back of their head unintentionally. The best

mouth gag I have found is a champagne cork. It is nice and round and considerably smaller on the inside, and you get a graduated gauge.

DR. SOHLEY: I have never noticed that symptom, but I have noticed a great deal of distress in the back of the head and upper part of the spinal column.

ULCERATIVE RHINITIS FOLLOWING DIPHTHERIA.

M. W. VAN DENBURG, A. M., M. D.,

FORT EDWARD.

The case I have to report is ulceration of the mucous membrane of the nostrils, following a severe attack of nasal diphtheria. For many months after convalescence large crusts were formed in each nostril every day, requiring removal from two to three times in twenty-four hours, and often followed by bleeding. At the end of a year they took the form of pus-covered casts of either nostril, reaching from front border of mucous lining, to posterior border of the lower turbinated bones. They were frequently unbroken, that is a complete tubular cast, at this period of a light yellow or greenish color, and about the size of an ordinary lead-pencil. They have gradually decreased up to the present, a period of six or seven years. I have not found anything that worked a complete cure.

In the first stages I feared ulceration of the turbinated bones, and necrosis. This stage was combatted with rhus tox., sulphur, and an occasional dose of thuya.

The second stage was most benefited by sepia, occasionally changed for thuya. With varying success, at times almost complete recovery promising, to be followed by relapse from colds or catarrhal troubles of nose and throat, and a relapse of former symptoms, the case has continued to the present.

At this writing these yellowish, semi-translucent scales and semi-casts are removed from one nostril one in once to three days. There is no bleeding, and no soreness. The young man is now in his nineteenth year, strong and well in every other respect. He has used spray applications, with glymole, never used nasal douches. For the past year he has had sepia 30[x] three times per week, for a month or two, to be followed by two or three doses of thuya, and a return to the sepia. I would be glad to receive suggestions for treatment.

TREATMENT OF HYPERTROPHIC RHINITIS.

C. E. TEETS, M. D.,

NEW YORK.

Before commencing the treatment of hypertrophic rhinitis, we should first be able to distinguish between an acute or transitory hypertrophy and a chronic or permanent hypertrophy. The mucous membrane lining the nasal cavities is composed of three layers. First, a superficial layer composed of epithelial cells. Second, a middle layer composed of connective and elastic tissues, muscular fibres, blood vessels, etc. And a third layer composed of a more or less loosely connected network of connective tissues and large venous sinuses which can be suddenly filled by the capillaries which open abruptly into them.

In transitory hypertrophy we have frequently recurring erections of the mucous membrane, especially of that portion covering the turbinated bodies, due to a weakness of the walls of the blood vessels of the middle, but principally of the third layer. This layer is composed almost entirely of blood vessels. The calibre of the blood vessels changes with the variations of temperature. It also changes from irritation caused by spurs, by deformed septums, and by particles of dust lodging upon the mucous membrane and allowed to remain there. In chronic or permanent hypertrophy we have a thickening as well as an increase in all the elements which go to make up the three layers. Therefore, while the first condition can be relieved and cured by internal remedies and mild local applications, the second can only be cured by surgical interference or the local application of a strong escharotic.

I have mentioned as one of the causes of hypertrophic rhinitis, particles of dust which are allowed to remain upon the mucous membrane. I mean by dust, fine, dry particles of earth, or other matter, so attenuated that it may be raised and wafted by the wind. The coarser particles of dust, such as are usually swept into our faces whenever we go upon the streets in dry and windy weather, consist largely of broken fibres of plants, pollen, fine hairs, ashes, fibres of clothing and other fabrics, particles of lime or sand, the pulverized excreta of various domestic animals, decayed vegetables, and clusters of various kinds of micro-organisms.

It is also well known that there are certain occupations where persons are confined to close rooms or to places where dust particles of one kind or another are very abundant. Thus day after day persons confined in air charged with coal, stone, woolen, metallic, tobacco, or any other kind of dust, are apt to become victims of catarrhal affections. Also in our homes we will find at times the finer particles of dust floating in the air.

Most of the air entering into the lungs should pass through the nose, so that the incoming air will not only be charged with moisture and heat, but will be separated from the particles of dust that are carried along with it. This is accomplished in two ways: first, by the vibrissæ at the entrance of the nostrils, which act as a sieve; and second, by the mucous membrane, which attracts the smaller particles which have escaped the guard at the entrance of the nasal cavities.

Now, it must be plain to one who has given any thought whatever to this subject, that if these particles of dust are allowed to remain for any length of time upon the mucous membrane there to undergo further decomposition, closing up the mouths of the glands, that it will not merely work harm and injury to that mucous membrane, but also to the general health. Therefore, in the treatment of acute or transitory hypertrophy I shall not only advise the use of certain remedies and local applications, but shall also advise as a prophylaxis, and to prevent further extension of the disease, the thorough cleaning of the nasal cavities once a day; this to be done with some non-irritating solution, either with an atomizer, douche, or a very small syringe. In my own practice I always advise the use of a small glass syringe, directing the patient as the piston rod is pushed in to gently snuff up the solution, propelling it along the nose to the naso-pharynx, cleansing this cavity and allowing it to pass out through the mouth.

I shall first call your attention to a new remedy for acute hypertrophic rhinitis. It has been used by some for insomnia, but not to my knowledge for acute hypertrophic rhinitis. It is the *passiflora incarnata*, or passion flower, found growing in dry soils throughout the south. I shall not take up your time describing to you how I came to discover its action upon the mucous membrane lining the nasal cavities, but will give only the indications for its use: Distressing pain at the root of the nose. Complete stoppage of one or both nostrils. Discharge slight and thick. Restless sleep. Dose, three to five drops of the tincture every three hours.

Senecio Aurens. Inability to fix the mind on any one object. Dull stupefying headache. Secretions slight or suppressed. Sneezing.

Burning and fullness in the nostrils—the burning being especially confined to the naso-pharynx. Dryness of the mouth and fauces; some pain in swallowing.

Lobelia Cerulea or Blue Lobelia. Great depression of spirits. Pain in the left side of head, and over the root of the nose. Itching and tingling in the left nostril, as if about to sneeze, followed by frequent sneezing, with copious discharge of mucus from both nostrils. Nostrils very sensitive, so that the inhalation of air creates a slighly painful feeling. This remedy is especially adapted to such cases as are subject to catarrhal inflammation of the posterior nares and fauces, and in which there appear upon the posterior wall of the pharynx red elevated spots, sometimes called follicular pharyngitis.

The other remedies to which I would call your attention (which you will find of great service, not merely alone but in connection with local treatment) and the indications for which I will refer you to the materia medica, are: aconite, belladonna, nux vomica, senega, gelsemium, arsenicum iod., kali iod., and bals-peruv.

Local treatment. Where there is a moderate amount of hypertrophy, but general throughout the whole nasal cavity, I use a saturated solution of the aceto-tartrate of aluminium. This is best applied by saturating a strip of lintine a half inch wide, and passing it back to the posterior nares by means of a flat applicator. This to remain from two to five minutes.

When the hypertrophy is more prominent and localized, I apply trichloracetic acid. When the acid is applied to the nasal mucous membrane a ten per cent. solution of cocaine should first be used to deaden sensibility. A small crystal is put on a probe flattened at the end and exposed to the air, when it becomes rapidly fluid. This is applied to the part which it is desirable to cauterize. Immediately after the application, a bright ivory white scab is formed, which remains localized at the point of application of the acid. It differs from the slough produced by chromic acid, in that it is uniformly thick, is almost inodorous, produces no unsatisfactory action, and leaves no unpleasant after-effects. The effects of the cauterization usually disappear within five or six days, when, if necessary, the cauterization may be repeated.

A rapid subsidence of the swelling may be brought about by the following treatment. Insufflations of aluminium aceto-tartrate with boric acid, equal parts, or one to two. This may be alternated with the galvano-cautery, which will afford notable subjective relief while promoting a cure. Or the following may be used: cocaine-phenate five parts, antifebrine ninety-five parts.

Antipyrine possesses a somewhat similar retractive effect to that of cocaine on the turbinated tissue. Sixteen to twenty-four grains to the ounce of water, with a few drops of glycerine, is as strong as can readily be borne and serve the purpose. It presents an advantage over cocaine, in avoiding numbness and dryness of the parts and over-stimulation of the nervous supply, and by producing a sedative action. The application causes smarting, and does not afford much relief in severe inflammation.

In chronic or permanent hypertrophy the redundant tissue may be removed by means of a strong acid, such as nitric, or it may be removed by the galvano-cautery, or by the cold wire snare. What I consider to be a better method, and one that will give satisfactory results, is to remove the redundant tissue with the scissors or with the cutting forceps.

Daly, of Pittsburg, treats hypertrophy of the turbinated tissue by making small punctures from time to time, so as to allow bleeding to the extent of one to three ounces. The results have been excellent, especially when the growths were erectile.

DISCUSSION.

L. A. BULL: I find in most all theatrical people a condition of irritable pharynx. The Doctor spoke of passiflora in acute rhinitis. I find plantago oil best in an ordinary case; if thrown in by an atomizer it gives relief, particularly in those cases that have been treated by old school rhinologists. With the addition of a little menthol it gives immense relief.

H. W. PAIGE: There is one thing that I am surprised Dr. Teets did not mention, and that is the stuffy condition, inability to breathe through the nose, thin watery discharge of the eyes, general prostration.

C. E. TEETS: My paper was only on hypertrophic rhinitis. I have used this treatment myself for eight months, cleaning my nose twice a day. It has been of great benefit. I have had less trouble from what is commonly called cold in the head, which I consider is nothing but irritation caused by dust on the mucous membrane, and I haven't had one patient yet who has followed this course of treatment but who has told me that they have been very much relieved and that it has been a very great advantage to them.

DR. PAIGE: Throwing aside the question of danger to the ear, which I will not bring up at all, the objection to syringing the nose for chronic or acute catarrh is the fact that in such a condition there is a great deal of hypertrophy and that the dust in those cases would be more likely to rush back on those structures, and an ordinary anterior syringe would not reach the whole tract involved; that would be the only objection.

SYPHILIS OF THE MOUTH AND THROAT WITH TREATMENT.

H. WORTHINGTON PAIGE, M. D.

NEW YORK.

The local manifestations of syphilitic toxæmia as found on the lips, in the mouth, or in the pharynx, are unfortunately of such frequent and ubiquitous occurence that every practitioner of medicine is familiar with their appearance and has had an experience in their treatment. There is no specialist however closely he may have confined himself to one line of research, who has not in the course of his study and investigation, come face to face with the syphilitic virus in the very organ in which he is particularly interested. There is no physician engaged in general practice who has not had an ample opportunity to observe the ravages that the systematic poisoning of this will work in an otherwise healthy constitution. From the babe at its mother's breast to the octogenarian, no age is exempt from the existence or resulting lesions of this disease. It is therefore with no little feeling of hesitation that I come before the members of this society with a paper on so familiar a subject, feeling that as I do not advance any new theories as to pathology or treatment I may be accused of repeating an oft told tale. I can only crave your indulgence on the ground that I have devoted some special attention to the disease as found in the throat, and to the fact that in an ailment that so often proves intractable under the usual methods of treatment, the old tale will bear repeating and any man's opinion is worthy of consideration.

According to its various conditions of development syphilis is divided into three stages, primary, secondary, and tertiary. Hereditary syphilis is not a distinct stage or condition of the disease but is so class-

ified for convenience. These three stages mentioned are subdivided according to the various successive manifestations of the disease upon the different tissues of the body. The mouth and throat may be the seat of any one or all of these three stages, although they are not as clear cut or well defined here as elsewhere, due probably to the functional activity of the parts exerting a modifying influence on the consecutive arrangement of the manifestations. Thus the primary may be prolonged by functional activity and merge into the secondary, or the secondary from local irritation or interrupted treatment resulting in true but superficial ulceration, may prolong until tertiary symptoms appear. Next to the genitals no location is so frequently the subject of syphilis as the mouth. The delicacy of the structures here, the extent and thinness of the mucous membrane, with its constant use and exposure; the frequency of fissures and abrasions; the rich distribution of blood vessels and absorbing glands, all combined with the functional activity of the parts renders this possible. There are so many ways of its introduction, directly or by mediation—by kissing, by loathsome habits, by tainted finger nails, through the medium of eating utensils, smoking the pipe of some dear but specific friend, in children from using whistles, bird-calls, etc., first tested by infected street venders. Otis cites a case of a merchant who contracted it through wetting on his tongue the pencil point of one of his clerks who had the disease, and last but not least through contamination from unclean instruments at the hands of one's own physician or dentist. These and many other ways by which the locality may become infected only serve to show the importance of close investigation of all incidents of daily life as a possible source of contagion in doubtful cases. It also illustrates the vital necessity that every dental or surgical instrument, tongue spatulas, drills, mirrors, etc., should be rendered scrupulously clean after contact with the mouth of a syphilitic patient by a thorough cleansing in a solution of bichloride of mercury, or by passing through the flame of an alcohol lamp, or both. It is best to have a *separate* set of instruments for use in specific cases.

Primary syphilis is not as frequently seen nor easily recognized in this locality as elsewhere. The subjective symptoms are not severe. The sore being usually single and small, sometimes very small, not particularly painful and to a certain extent self-limiting as to duration, generally healing in two or three weeks, the chancre itself may pass unrecognized. If the patient himself discovers it and knows whereof it is, pride often prevents his presenting himself for treatment, unless the ulcer becomes extensive, or tender, or he is particularly alarmed by its

presence. If he does so it is often with a very meagre array of collateral evidence as to infection and we have to base our diagnosis on the purely objective appearance of the sore. The primary lesion is always a chancre whether the infection was from a primary or secondary lesion. It may take the form of a simple erosion or a superficial ulcer. It is most commonly found on the lips particularly at the corners (where fissures are liable to exist) less frequently on the tongue, and rarely but nevertheless surely on the tonsil. Other parts back of the palatal pillars are almost exempt from the visitation of primary lesion. It is claimed by most writers that it is absolutely necessary for the virus to come in contact with an abrasion of surface in order to infect. I believe this holds good as far as the lips, cheek lining, surface of the tongue or in fact any surface where functional activity would keep the mucous membrane clean. But in case of the tonsil it is different. Here the poison might lodge in the lacunæ and remain undisturbed until absorbed, thereby infecting the part. It would seem to me that the same might be true under the tongue. In other words any point where the virus could lie undisturbed for a length of time would become infected by absorption without the previous existence of an abrasion, or again its irritating qualities might create its own erosion. The diagnosis of chancre should be based on the single sore and the induration about it together with the induration of the neighboring lymphatics and general indolent condition of the ulcer with comparative freedom from pain. Where these symptoms are not well defined nor supported by a clear history, rendering the diagnosis obscure, we should express a guarded opinion until the development of secondary symptoms. The chancroid or soft chancre may occur in the mouth although it is rarely seen there. When found it is distinguished by the multiple sore, free discharge and tendency to rapid phagedenic destruction of tissue. In view of the frequency and great auto-contagiousness of this disease it is a wonder that it is not more commonly found in the mouth.

Secondary syphilis is the stage of the disease with which we are all most familiar in treating diseases of the throat. The primary sore has healed satisfactorily and the patient unless forewarned has lulled himself into a blissful state of content that the disease is cured. But in a period varying from three weeks to two months his dream is rudely broken by the appearance of these secondary symptoms.

The mouth and throat lesions of the secondary stage are far more distressing than the primary. Multiple in character, irritable and painful, accompanied by roseolous or papillomatous syphilides, and later the tendency to more or less alopecia, form a combination to make the

patient thoroughly miserable. These lesions are if possible more virulent than the primary. Probably because they are more active, more numerous, and in a locality where others are more apt to come in direct or indirect contact with them or their virus. The secondary manifestations in the throat have distinctive characteristics of their own and yet having some in common with other diseases of this locality, it behooves us to consider and examine them carefully before pronouncing a positive opinion or instituting anti-syphilitic treatment.

Erythema and the mucous froth are the two trump cards played at this stage of the game. The *erythema* of syphilis on the mucous membrane is characteristic and cannot easily be mistaken for that of any other condition. Its three specific traits are: 1st, a sharp line of demarcation between it and the healthy surface—no blending or shading off. 2nd, the "arborescent appearance," that is an inter-weaving, fern-like arrangement of engorged capillaries over a red background—this in contradistinction to the phthisical throat which presents a similar network playing over a pale, anæmic back ground. 3d, the uniform distribution of the blush on both sides. The mucous tubercle or mucous patches, usually multiple, appear during this stage. Their most frequent site is on the pillar and veil of the palate, and lips; they are also found on the tongue, roof of the mouth and the buccal mucous membrane generally except the pharyngeal wall where the lesions of this stage are rarely seen. The *mucous patch* is not a true ulceration but rather an erosion i. e. the mucous membrane denuded of its epithelium. It is usually rather oval and regular in contour being most often distributed symetrically as to size and location, on both sides. So frequently is this the case that it has come to be regarded as a characteristic feature of this stage, and is termed the "Dutch garden" arrangement as a tribute to its regularity. The mucous patch is superficial, surrounded by a red areola. It looks irritable and is sore. It creates a foul breath and heavily coated tongue which shows the imprints of the teeth. Bad teeth by the way may irritate the tongue and be an exciting cause to further mucous patches where syphilis is present. The mouth is constantly filling with saliva, and there is a red line running along the margin of the gums, which tend to recede from the teeth and bleed easily. Truly a good likeness of mercury. Accompanying these symptoms the enlargement of neighboring lymphatics especially of the occipital and post cervical region. These combined with the usual cutaneous manifestations make a group not easily mistaken for anything else by the careful observer, especially if a history of primary sore is obtainable.

These mucous plaques if they remain in the innocent simplicity of their first appearance, disappear as a rule in from six weeks to two months and usually yield well to treatment during that time; but they are prone to be sensitive, and if irritated by tobacco or alcohol, by friction of food and the general functional activity of the parts, a necrosis of tissue begins and an actual ulcer results. Superficial as a rule and not as destructive as the tertiary but nevertheless an ulcer prone to cause neighboring swelling of an œdematous character and with a tendency to resist treatment and prolong for six months or even a year, sometimes disappearing for a time, then breaking out again, especially if the treatment as is so frequently the case, be irregular and interrupted. This condition of the secondary lesions is particularly liable to assert itself in those patients having a debilitated constitution or strumous diathesis. It thus may be very obstinate and its best prevention is avoidance of all local irritation, good hygiene and persistent, careful attention to treatment.

Tertiary Syphilis.—Some of the leading writers notably among the modern men, do not regard the tertiary as a stage of the disease in the accepted sense of the term, but rather as a chain of sequelæ. In support of this they cite the fact claimed by such syphilographers as Diday, Ricord and Hutchinson that the results of tertiary ulceration under the microscope show only normal cell tissue broken down and that it is not communicable by inoculation or inheritance. Be that as it may or regard it as we will, the practical fact remains that the processes of tertiary syphilis in the throat are most disastrous. Muscle, cartilage and bone disappear by its destructive ulceration and when stayed distorting cicatrices are left to mark the path of its ravages. The manifestations of this stage appear in from two to twenty years after the primary sore. During the interval between the cessation of the secondary symptoms and the appearance of the tertiary, the patient regards himself as cured, and often this interval is so long, and so fixed is the idea of cure in the mind, that it is frequently very difficult to get a good history of the primary stage, as the patient seems reluctant even to the point of obstinacy, to recognize or admit a possible connection between the two, and regards our questions about his earlier indiscretions as impertinent or irrelevant. The lesions of tertiary syphilis unlike those of primary or secondary are most prone to attack the pharyngeal region—the palatal pillars, velum palati and uvula and the posterior pharyngeal wall. Unlike the ulceration of the other stages they are deeper and more destructive. As Lancereaux aptly says "they gain in depth what they lose in extent."

Mackenzie classifies them as superficial and perforating. This division as the terms imply being one of degree only. The ulcers may be single or multiple. They look indolent and angry, with pale base covered with fungoid granulations and free discharge of pus consisting of necrotic tissue elements. The tendency is to extend and work deeply, attacking successively soft tissue, cartilage, and bone. If the patient's vitality is below par or he is of scrofulous habit the ulceration may assume a phagedenic character and work very rapid destruction. The tumefaction engendered by and about the seat of ulceration causes contact of opposing surfaces normally separate. The ichorous discharge creates abrasion, adhesions resulting which seriously interfere with normal functions. Notably adhesions often met with between the velum palati and the post-pharyngeal wall, or between the uvula and the palatal pillars, or the latter and the pharyngeal wall. Another common lesion is a perforating ulcer at the base of the uvula extending therefrom until the velum palati is destroyed, resulting in thick nasal voice and regurgitation of fluids through the nose.

The *Prognosis* in all these stages of syphilis is very favorable to life. A bad case of tertiary, especially if based on an ill-nourished, scrofulous diathesis, might result in such extensive ulceration and bony necrosis as to cause death by exhaustion. Death might ensue from deep ulceration on the posterior wall of the pharynx resulting in caries of the bodies of the vertebræ with consequent lesion of the spinal cord or medulla, or by invasion of a blood-vessel cause a fatal hæmorrhage. But these cases are very rare, the tendency being to revolution and cicatrization in the vast majority of cases.

Differential Diagnosis. In the secondary and particularly the tertiary stages the mouth and throat lesions might be mistaken for other diseases, notably cancer. With the latter, however, there is more pain, a single sore with less destruction of tissue, and the characteristic cachexia. The ulcers of a tuberculous origin are smaller than those of secondary syphilis but comparatively more painful. The mucous membrane is very pale and anæmic, and hypersensitive to touch and examination. The uvula is constantly tremulous when the tongue is depressed, together with increased temperature, cough and other well-known constitutional symptoms.

Lupus has a pale throat, very slow progress of ulceration, marked anæsthesia; not a well defined ulcer, more of a gap and deeper than tuberculosis. Bosworth says "it belongs essentially to the skin," and hence in the majority of cases is accompanied by cutaneous manifestations. The microscope is of great negative value in differentiating

between syphilis and these other affections. But in all cases supposed to be syphilitic, where there is a doubt however about the diagnosis, the effect of the treatment later described is the crucial test. Proper anti-syphilitic treatment will yield prompt benefit to all cases syphilitic in nature, but in other conditions will either aggravate or not affect at all.

Hereditary Syphilis. When we come to hereditary syphilis, writers differ in opinion as to how far the disease can effect the fœtus in utero, some claiming that the secondary symptoms must be the first ones that manifest themselves after birth. In my own experience the lesions of infants or children presented for treatment have been of a decided tertiary character. The symptoms at this age are not easily mistaken. The poison tends to run a rapidly destructive course as regards necrosis of the nasal and palatal bones. Erosions and ulceration of the nasal structures with acrid discharge, cause nasal obstruction, cracked nostrils and excoriated lips. There is usually a flattened nose from caries of the nasal cartilages and bones. The nasal stenosis prevents the child taking the breast properly and as a consequence it looks anæmic, puny and ill-nourished. The mouth and throat lesions are those of tertiary syphilis in the adult, with a greater trend to rapid invasion and caries of osseous structures. A peculiar and characteristic symptom of hereditary syphilis is the notched edges of the incisor teeth, the so-called "Hutchinson teeth." This is a strong point in differentiating between the acquired and hereditary disease. The prognosis of hereditary syphilis should be guided by the general condition of the child, the extent of the local trouble, and the length of time after birth that the disease appears. The earlier seen the less favorable as to life and cure. If the symptoms develop well before it is two years of age it rarely lives. When a syphilitic catarrh and cutaneous eruption appear before the child is two months old, it usually dies in spite of treatment. Lennox Browne states that if pharyngeal ulceration is manifested during the first year of life, the patient will not live as a rule. These little patients die of malnutrition, or exhaustion from the constant drain upon the vitality by the disease process going on.

Treatment. My personal experience in the remedial treatment of syphilis of the mouth and throat has been limited to two principal remedies, mercury and kali iodide, with aurum or nitric acid as accessories. I have given other remedies for collateral symptoms or conditions, but for the power behind the throne, the syphilitic intoxication itself, I pin my faith to the drugs mentioned. I believe that to be effectual they must be given in low potency and, in the case of mercury and kali, in

appreciable doses. I have used them in higher potencies as I was taught to do, but was disappointed in not relieving my cases and while I have met several who advocate the administration of the medium or higher potencies in this disease and speak of cures thus made, I have never seen these results demonstrated. This doubt coupled with the fact that the stronger doses of these drugs do so promptly and satisfactorily benefit the vast majority of these cases makes me think it is unwise for me at least to experiment further. When this treatment fails I believe it is because it was not faithfully or properly carried out. And I also believe that unless there is some subtle influence at work which makes a given case incurable, that the disease can be cured by these drugs. It is essential to good results that the constitutional treatment should be assisted by faithful and thorough local treatment, especially in the secondary and tertiary stages. The primary lesion, the chancre requires but little local attention. It should be kept clean by some antiseptic mouth wash, such as carbolized glycerine or borated glycerine in water, or the antiseptic solution, Dr. Seiler's formula, for which tablets are prepared. It should also be free from irritation by hard, dry or highly seasoned food, tobacco and alcohol. Internally administer one powder of mercurius sol.[1], three times daily after each meal. Some prefer to give it in the[1x], others like the protiodide or the biniodide in similar potency. Personally I think the merc. sol. or viv. best indicated and most satisfactory in this stage, and prefer the first centesimal because its effect is eminently satisfactory with less danger of inducing drug symptoms. The administration should be carfully observed, and diminished if symptoms of mercurialism appear. This treatment will usually heal the sore in two weeks and exerts a modifying influence on the secondary symptoms. Right here let me say that throughout the treatment of syphilis in each stage, the teeth should be thoroughly and frequently cleansed. If a brush proves too harsh, rub them with a cloth and if there is tenderness of the gums add fifteen drops of tincture of myrrh to the glass of mouth or tooth wash. The secondary stage requires more attention locally and constitutionally than the primary, although Mackenzie says, " Secondary syphilis of the pharynx does not usually require any constitutional remedies," and claims that he rarely meets tertiary symptoms if the local treatment has been thorough in the secondary stage. In this he is combated by all other writers to whose works I have access. The local treatment consists in altering the irritable, eroding surface and edges of the patch, destroying fungoid granulations and stimulating to a healthy reaction. This may be best accomplished by a thorough application of the nitrate of silver stick to each

plaque or superficial ulceration. It is best to touch every part thoroughly and deeply rather than superficially. The process is not usually painful, but if it is so a four per cent. solution of hydrochlorate of cocaine may be first applied. New patches should be looked for and cauterized as soon as discovered. Accompanying this should go a thorough but very careful gargling, because of its poisonous properties, with a solution of bichloride of mercury three grains to eight ounces of water. This I regard as essential to prompt relief. Constitutionally the treatment should be the so called "mixed." Here the iodides of mercury seem best indicated. Some prefer the biniodide. My personal choice is the protiodide given a two grain powder at ten, three, and bed time. In connection with this I administer the saturated solution of kali iodide, beginning with three drops after each meal in water, and increasing the dose by one drop more each day until the point of toleration (as indicated by coryza and rash) is reached or the disease yields. The three essential points to its successful administration are, 1st. the very gradual increase, only one drop per dose daily; 2d. taken on a full stomach; and 3d. in an abundance of water. I have never seen any unpleasant result upon the patient by this method and the most desperate looking cases are promptly benefited. The merc. prot. might be given in the first if the disease seemed intractable, though I have never had occasion to give it so. The gargling should be stopped when all mucous patches have disappeared and the erythema is much diminished. The maximum dose of the kali iodide necessary to accomplish this is usually from fifty to sixty drops (equivalent to that number of grains) three times daily, although much more may be given without ill effects, if required to do the work. It is well to hold it there for a number of days and then decrease the dose in the same manner as it was increased, i. e., one drop less per dose daily, until ten drops per dose is reached. This dose with the merc. prot. should be continued for three months when the kali may be suspended and a dose of the protiodide given twice daily for a year longer. Any evidence of a return of the throat trouble should be met with a prompt increase in the kali iod. or a renewal of the treatment if it has been suspended.

Tertiary syphilis of the mouth and throat requires prompt, thorough and persistent treatment local and constitutional. The victims of this stage of the disease are usually anæmic and debilitated. The systemic toxæmia and its local destruction processes are a drain upon their vitality. Function and reactive powers are all sluggish. Hence the necessity for sharp, strong and active treatment. The food should be highly nutritious, the general hygiene all good. In addition to the

regular anti-syphilitic treatment ferr. met.', china and cod liver oil may be advantageously exhibited. The constitutional treatment is simple. It consists in the administration of its kali iodide by the same method as in the secondary stage but without the mercury. Pushing it slowly but surely up to its maximum dose or until the local process and general condition improve. It should be held at that dose until all local ulceration or necrosis has disappeared, and then gradually reduced until a ten drop dose is reached, this to be continued for an indefinite length of time—one or two years—and promptly increased if the disease shows any signs of reasserting itself. The local treatment consists in cleanliness and stimulation. The raw surfaces should be rendered free from all discharge by direct application of hydrogen peroxide. Irritable edges of indolent granulations may be stimulated by the caustic stick, but I do not believe in its thorough and deep application or that of the electro-cautery to the lesions of this stage. If tissue necrosis has reached osseous structure, all bony sequestra should be detached and removed as soon as found and the locality thoroughly cleansed as before. If the disease in the nose contributed an ichorous discharge to the pharynx it should be thoroughly syringed with a weaker solution of hydrogen peroxide or other antiseptic solution before attempting to make application to the throat lesions. Then each ulcer should be thoroughly covered with powdered iodoform diluted with one-fourth part of boric acid. I have tried solutions of various drugs in oil and water and believe that insufflations of dry powders yield best results.

I have also used aristol, europhen, iodol, pyoktanin, the various substitutes for iodoform and come back to borated iodoform as the most satisfactory all round, if not the most agreeable. This treatment should be carried out as often as necessary to keep the parts clean and must be kept up until all raw surfaces are healed.

In hereditary syphilis of children if the same local treatment is necessary, it should if possible be carried out although this is more easily said than done in the case of very young children. The same internal remedies are required though in doses proportionate to age. Children tolerate mercury better in proportion than adults, and so the first centesimal may be given in a one grain powder three times daily. Kali iodide may be given in gradually increasing doses, although in the case of children I have usually given three to five drops, according to age, without increase, twice or three times daily with happy results. In infants the first centesimal of kali iod. works nicely. Nitric acid is well indicated symptomatically in the secondary as well as the tertiary for the patches and fissures, especially if with sticking pains. Aurum met., or mur.,

presents a good picture of the tertiary nasal symptoms but has not as large an application in the throat.

During the active processes of the disease I have not met with good success from either of these drugs and prefer to trust to mercury or kali or both. The field for aur. 3, nitr. ac. 1, or kali iod. 1 or 3 at my hands has been in nasal and pharyngeal catarrhs, ozænas, etc., following along after the active manifestations of the secondary or tertiary stages have been relieved, or in cases wherein there is a suspicion of a latent taint, acquired or hereditary. They are also especially valuable in children with hereditary syphilitic catarrhs and glandular troubles of a passive nature. I believe that the views here expressed are in accord, in general if not in detail, as to the manner and method, with the majority of throat specialists in relieving the unfortunate victims of the insidious, treacherous and destructive malady. There may be physicians who eradicate it with higher potencies and no local treatment, I have met them, but knowing what I do of the disease in my comparatively limited experience, if I was so unfortunate as to contract it I should surely have neurasthenia as complication if I were under their professional care.

REPORT

OF THE

BUREAU OF OPHTHALMOLOGY AND OTOLOGY.

"Observations with Javal's Ophthalmometer," - ELMER J. BISSELL.
"Reflex Neuroses from Eye-strain," - - - - A. B. NORTON.
"Senega in the Treatment of Hyperphoria and its Resultant Symptoms," - - - - E. H. LINDELL.
"Ulcer of the Cornea cured by Chin. mur.," - - ALTON G. WARNER.
"Dislocation of the Lens, and Subsequent Cataract, by a shot from an Air-gun," - - ALTON G. WARNER.
"A Case of Nuclear Iridoplegia," - - - - CHAS. C. BOYLE.
"Sound as a Factor in the Treatment of Disease of the Sound Conducting Apparatus," - HENRY C. HOUGHTON.

OBSERVATIONS WITH JAVAL'S OPHTHALMOMETER.

ELMER J. BISSELL, M. D.,

ROCHESTER.

Not until Javal produced the model of 1889 did the ophthalmometer bearing his name come into general use. Until recently, therefore, little was written regarding its usefulness in refraction work. Sufficient time, however, has now elapsed since the introduction of this perfected instrument for careful observation, and our current literature is beginning to present the results.

These reports do not agree in all particulars, but, in the main, a general harmony prevails. All observers agree that it is a scientific and practical instrument, and that they could not well dispense with it.

Like all new instruments and methods which possess real merit, it suffers at the hands of the over enthusiastic. Some claim that by its use they no longer find it necessary to employ atropine, or homatropine,

in determining the refraction; others would have you believe that they can largely dispense with former objective tests and accurately prescribe astigmatic glasses from the data furnished by the ophthalmometer.

If ophthalmic science has demonstrated anything, it is that astigmatism is the cause of much suffering, and that to meet the needs of all cases, varied and repeated tests, coupled with good judgment, are necessary.

What is most needed now is to find out just what this instrument will do, and to clearly distinguish what it will do in *every* case from what it will do in possibly a majority of cases. Then its place in our armamentarium will have been determined, and we will know how much reliance to place upon our observation with it. With this end in view, I have tabulated from my case book five hundred (500) eyes out of about eight hundred which I have examined with the ophthalmometer, and have made four classifications.

I. Eyes in which the ophthalmometer, retinoscopy, and the subjective tests showed no astigmatism.

II. Eyes in which each of the three tests showed the *same* amount of astigmatism.

III. Eyes in which the ophthalmometer showed a *greater* amount of astigmatism than the other tests.

IV. Eyes in which ophthalmometer showed *less* astigmatism than the other tests.

The table is arranged to show the age of the patient; the astigmatism indicated by the ophthalmometer; the amount found by retinoscopy; the cylindrical glass prescribed; the difference between the prescribed cylindrical and the amount determined by the ophthalmometer; the axis to the meridian of the least corneal curvature; the axis of the cylinder prescribed; the general character of the refraction, and the cases in which a mydriatic was employed.

CLASS I.

No. of Eye.	Case Book No.	Age.	Right or Left Eye.	General Refraction of eye.	Mydr. Employ'd Marked X.	No. of Eye.	Case Book No.	Age.	Right or Left Eye.	General Refraction of Eye.	Mydr. Employ'd Marked X.
1	7325	54	R.	H.	..	41			L.	M.	X
2			L.	H.	..	42	7250	47	R.	H.	..
3	7316	16	R.	H.	..	43			L.	H.	..
4			L.	H.	..	44	7249	45	R.	H.	..
5	7314	58	R.	H.	..	45			L.	H.	..
6			L.	H.	..	46	7245	31	L.	H.	X
7	7312	18	R.	E.	..	47	7242	30	R.	E.	..
8			L.	E.	..	48			L.	E.	..
9	7310	6	R.	H.	..	49	7238	28	R.	M.	..
10			L.	H.	..	50	7234		L.	M.	..
*11	7308	45	R.	H.	X	51	7233	70	R.	H.	..
*12			L.	H.	X	52			L.	H.	..
13	7305	33	R.	H.	..	53	7232	46	R.	H.	..
14	7304	36	R.	E.	..	54			L.	H.	..
15			L.	H.	..	55	7229	47	R.	E.	..
16	7299	43	R.	H.	X	56			L.	E.	..
17			L.	H.	X	57	7227	56	R.	E.	..
18	7298	48	R.	H.	..	58			L.	E.	..
19			L.	H.	..	59	7223	18	R.	H.	X
†20	7292	4	R.	H.	X	60			L.	H.	X
21			L.	H.	X	61	7220	?	R.	M.	X
22	7291	23	L.	H.	X	62	7214	40	L.	E.	..
23	7289	58	R.	H.	..	63	7208	12	R.	E.	..
24			L.	H.	..	64			L.	E.	..
25	7286	22	R.	E.	..	65	7205	15	R.	E.	..
26			L.	E.	..	66			L.	E.	..
27	7281	20	R.	H.	..	67	7203	40	R.	E.	..
28			L.	H.	..	68			L.	E.	..
29	7280	23	R.	H.	X	69	7201	23	R.	H.	..
30			L.	H.	X	70			L.	H.	..
31	7270	35	L.	H.	..	‡71	7200	74	R.	H.	..
32	7267	53	R.	H.	..	‡72			L.	H.	..
33			L.	H.	..	73	7198	65	R.	H.	.
34	7266	50	R.	E.	..	74			L.	H.	..
35			L.	E.	..	75	7196	12	R.	H.	X
36	7265	38	R.	H.	..	76			L.	H.	X
37	7263	9	L.	H.	X	77	7193	15	R.	H.	X
38	7260	20	R.	H.	..	78			L.	H.	X
39			L.	H.	..	79	7191	22	R.	E.	..
40	7253	21	R.	M.	X	80			L.	E.	..

*Optic neuritis. †Converging strabismus. ‡Incipient cataract.

CLASS I—*continued.*

No. of Eye.	Case Book No.	Age.	Right or Left Eye.	General Refraction of Eye.	Mydr. Employ'd Marked X.	No. of Eye.	Case Book No.	Age.	Right or Left Eye.	General Refraction of Eye.	Mydr. Employ'd Marked X.
81	7187	21	L.	E.	..	119			L.	H.	..
82	7186	71	R.	H.	..	120	7329	25	R.	E.	..
83			L	H.	..	121	7113	49	R.	H.	..
84	7181	68	R.	H.	..	122			L.	H.	..
85			L.	H.	..	123	7105	34	R	H.	..
86	7180	35	R.	H.	X	124			L.	H.	..
87			L.	H.	X	125	7094	38	R.	E.	..
88	7177	30	L.	H.	X	126			L.	E.	..
89	7176	18	R.	H.	X	127	7088	10	R.	H.	..
90			L.	H.	X	128			L.	H.	..
91	7175	37	R.	M.	..	129	7085	55	R.	H.	..
92	7172	33	R.	E.	..	130			L.	H.	..
93	7171	18	R.	H.	..	131	7083	43	R.	H.	..
94	7167	61	R.	M.	X	132			L.	H.	..
95			L.	M.	X	133	7081	16	R.	H.	X
96	7164	65	L.	H.	..	134			L.	H.	X
97	7166	48	R.	H.	..	135	7070	62	R.	H.	..
98			L.	H.	..	136			L.	H.	..
99	7163	38	L.	H.	X	137	7065	63	R.	H.	..
100	7160	9	R.	H.	X	138			L.	H.	..
101			L.	H.	X	139	7328	63	R.	H.	..
102	7152	52	R.	H.	..	140			L.	H.	..
103	7143	59	R.	H.	..	141	7054	19	L.	H.	X
104			L.	H.	..	142	7049	8	R.	H.	X
105	7136	49	R.	H.	..	143			L.	H.	X
106			L.	H.	..	144	7335	52	R.	M.	..
107	7134	32	R.	M.	..	145	7047	47	R.	E.	..
108			L.	M.	..	146			L.	E.	..
109	7131	58	R.	H.	..	147	7045	58	R.	H.	..
110			L.	H.	..	148			L.	H.	..
111	7128	13	L.	H.	..	149	7042	47	R.	H.	..
112	7126	20	L.	H.	..	150			L.	H.	..
113	7123	5	R.	H.	..	151	7037	33	R.	H.	..
114			L.	H.	..	152			L.	H.	..
115	7119	30	R.	M.	..	153	7330	47	R.	H.	..
116			L.	M.	..	154			L.	H.	..
117	7118	29	R.	E.	..	155	7335	22	R.	H.	X
118	7117	46	R.	H.	..						

CLASS II.

No. of Eye.	Case Book No.	Age.	Right or Left Eye.	Astigmatism by Ophthalmometer.	Astigmatism by Retinoscopy.	Glass Prescribed.	Difference between Glass and Ophthalmometer.	Axis to Meridian of Least Curvature.	Axis of Glass Prescribed.	General Refraction of Eye.	Mydr. Employed Marked ×
1	7323	16	L.	.25	+ .25	+ .25	=	90°	90°	E.	..
2	7322	45	R.	.25	+ .25	+ .25	=	90	90	H.	..
3			L.	.25	+ .25	+ .25	=	90	90	H.	..
4	7309	19	L.	2.00	+2.00	+ 2.00	=	105	105	H.	..
5	7306	17	R.	.75	— .75	— .75	=	90	180	M.	..
6			L.	.75	— .75	— .75	=	90	180	M.	..
7	7297	..	R.	.50	+ .50	+ .50	=	90	90	H.	×
8			L.	.50	+ .50	+ .50	=	90	90	H.	×
9	7291	23	R.	.25	+ .25	+ .25	=	90	90	H.	×
10	7290	18	R.	.25	+ .25	+ .25	=	90	90	H.	×
11	7279	17	R.	.25	+ .25	+ .25	=	90	105	H.	×
12			L.	.50	+ .50	+ .50	=	90	90	H.	×
13	7278	12	L.	.25	+ .25	+ .25	=	90	90	H.	×
14	7275	26	R.	.25	+ .25	+ .25	=	90	90	H.	×
15			L.	.50	+ .50	+ .50	=	90	90	H.	×
16	7274	32	R.	.50	+ .50	+ .50	=	90	90	H.	..
17			L.	.50	+ .50	+ .50	=	90	90	H.	..
18	7271	42	R.	.50	+ .50	+ .50	=	90	105	H.	×
19			L.	.25	+ .25	+ .25	=	90	75	H.	×
20	7270	35	R.	.25	+ .25	+ .25	=	75	75	H.	..
21	7268	23	R.	.25	+ .25	+ .25	=	90	75	H.	×
22			L.	.50	+ .50	+ .50	=	90	105	H.	×
23	7263	9	R.	.25	+ .25	+ .25	=	90	90	H.	×
24	7258	23	L.	.50	+ .50	+ .50	=	90	90	H.	×
25	7254	49	R.	.25	+ .25	+ .25	=	90	75	H.	..
26	7241	19	R.	.50	+ .50	+ .50	=	90	90	H.	×
27			L.	.25	+ .25	+ .50	=	90	90	H.	×
28	7237	22	R.	.25	+ .25	+ .25	=	90	90	H.	×
29			L.	.25	+ .25	+ .25	=	90	90	H.	×
30	7236	..	L.	.25	+ .25	+ .25	=	90	90	H.	×
31	7231	..	R.	.25	+ .25	+ .25	=	90	90	E.	..
32	7224	15	R.	.50	+ .50	+ .50	=	90	90	H.	×
33			L.	.50	+ .50	+ .50	=	90	105	H.	×
34	7218	52	R.	.50	+ .50	+ .50	=	180	180	H.	..
35	7217	37	R.	.50	+ .50	+ .50	=	90	90	H.	×
36	7216	22	R.	.25	+ .25	+ .25	=	90	90	H.	×
37			L.	.25	+ .25	+ .25	=	90	90	H.	×
38	7214	..	R.	.25	+ .25	+ .25	=	90	90	E.	..
39	7212	26	R.	.25	+ .25	+ .25	=	90	90	H.	×

CLASS II—*Continued.*

No. of Eye.	Case Book No.	Age.	Right or Left Eye.	Astigmatism by Ophthalmometer.	Astigmatism by Retinoscopy.	Glass Prescribed.	Difference between Glass and Ophthalmometer.	Axis to Meridian of Least Curvature.	Axis of Glass Prescribed.	General Refraction of Eye.	Mydr. Employed Marked ×
79	1091	30	R.	.50	+ .50	+ .50	=	90°	90°	H.	×
80			L.	.50	+ .50	+ .50	=	90	90	H.	×
81	7086	9	L.	.25	+ .25	+ .25	=	90	90	H.	×
82	7077	18	L.	.50	— .50	— .50	=	90	180	M.	..
83	7068	33	R.	.50	+ .50	+ .50	=	90	70	H.	×
84			L.	.75	+ .75	+ .75	=	90	90	H.	×
85	7057	10	R.	.25	+ .25	+ .25	=	90	90	H.	×
86			L.	.50	+ .50	+ .50	=	90	90	H.	×
87	7052	43	R.	1.25	+1.25	+1.25	=	15	10	H.	×
88	7048	..	L.	1.00	+1.00	+1.00	=	90	85	H.	×
89	7040	..	R.	.50	+ .50	+ .50	=	90	85	H.	×
90			L.	.50	+ .50	+ .50	=	90	95	H.	×
91	7039	21	R.	.50	— .50	— .50	=	90	180	M.	×
92			L.	.50	— .50	— .50	=	105	15	M.	×
[1]93	6087	27	L.	4.00	+4.00	+4.00	=	10	10	H.	..
[2]94	5066	42	L.	3.00	+3.00	+3.00	=	75	60	H.	..
[3]95	5066	42	L.	1.25	+1.25	+1.25	=	75	75	H.	..
[1]96	5008	61	R.	2.25	+2.25	+2.25	=	180	180	..	..
97	7334	23	R.	.75	+ .75	+ .75	=	90	90	H.	..
[4]98	7351	17	L.	.25	+ .25	+ .25	=	90	180	H.	×
99	7340	26	R.	.25	+ .25	+ .25	=	90	90	H.	×
100			L.	.25	+ .25	+ .25	=	90	90	H.	×
101	7076	35	L.	2.00	+1.50 — .50	+1.50 — .50	=	90	90	..	×
102	7075	26	R.	4.50	+4.00 — .50	+4.00 — .50	=	70	70	..	×
103	6225	26	R.	1.00	+1.00	+1 00	=	90	80	H.	×
[4]104	6326	22	R.	.25	— .25	— .25	=	90	90	M.	×
105			L.	.25	+ .25	+ .25	=	90	110	H.	×
106	6478	18	R.	.25	+ .25	+ .25	=	80	90	E.	×
107			L.	.50	+ .50	+ .50	=	90	90	E.	×
[5]108	6449	78	L.	1.50	+1.50	+1.50	=	180	180	..	..
109	652	18	R.	.25	+ .25	+ .25	=	90	90	H.	×
110			L.	.25	+ .25	+ .25	=	90	90	H.	×

1 After cataract. 2 With chalasion. 3 After removal.
4 Axis against rule. 5 After cataract extraction.

CLASS II—*Continued.*

No. of Eye.	Case Book No.	Age.	Right or Left Eye.	Astigmatism by Ophthalmometer.	Astigmatism by Retinoscopy.	Glass Prescribed.	Difference between Glass and Ophthalmometer.	Axis to Meridian of Least Curvature.	Axis of Glass Prescribed.	General Refraction of Eye.	Mydr. Employed Marked ×.
40			L.	.25	+ .25	+ .25	▬	90°	90°	H.	×
41	7210	43	L.	.50	+ .50	+ .50	▬	90	90	H.	..
42	7204	24	R.	.25	+ .25	+ .25	▬	90	90	H.	..
43	7199	14	R.	.50	+ .50	+ .50	▬	90	90	H.	×
44	7194	35	R.	.25	+ .25	+ .25	▬	90	90	H.	×
45			L.	1.00	+1.00	+1.00	▬	90	90	H.	×
46	7190	16	L.	.75	— .75	— .75	▬	180	75	M.	×
47	7188	..	L.	.25	+ .25	+ .25	▬	90	90	H.	×
48	7171	18	L.	.50	+ .50	+ .50	▬	90	90	H.	..
49	7184	24	R.	.25	+ .25	+ .25	▬	90	90	H.	×
50			L.	.75	+ .75	+ .75	▬	90	90	H.	×
51	7173	17	R.	.50	+ .50	+ .50	▬	90	90	H.	×
52			L.	.25	+ .25	+ .25	▬	90	90	H.	×
53	7159	..	R.	.75	+ .75	+ .75	▬	90	90	H.	×
54			L.	.25	+ .25	+ .25	▬	90	105	H.	×
[1]55	7157	44	R.	.25	..	+ .25	▬	120	30	E.	..
[1]56			L.	.25	..	+ .25	═	50	145	E.	..
57		38	R.	.25	..	+ .25	═	90	80	H.	×
58			L.	.25	+ .25	+ .25	═	90	90	H.	×
59	7152	52	L.	.25	+ .25	+ .25	═	90	90	H.	..
60	7148	..	R.	.75	+ .75	+ .75	═	90	90	H.	×
61			L.	.50	+ .50	+ .50	═	90	90	H.	×
62	7145	9	R.	1.00	+1.00	+1.00	═	90	90	H.	×
63			L.	.50	+ .50	+ .50	═	90	85	H.	×
64	7142	37	R.	.50	+ .50	+ .50	═	90	90	H.	×
65			L.	.25	+ .25	+ .25	═	90	85	H.	×
66	7138	30	R.	.25	+ .25	+ .25	═	90	90	E.	..
67			L.	.25	+ .25	+ .25	═	90	90	E.	..
68	7132	27	R.	.25	— .25	— .25	═	75	145	M.	×
69	7130	30	R.	.25	+ .25	+ .25	═	90	75	H.	×
70	7115	19	L.	.25	+ .25	+ .25	═	90	90	H.	×
71	7112	32	L.	.25	+ .25	+ .25	═	90	90	H.	×
72	7111	40	R.	.75	+ .75	+ .75	═	90	90	H.	..
73			L.	.50	+ .50	+ .50	═	90	90	H.	..
74	7099	38	L.	.25	+ .25	+ .25	═	90	100	H.	×
75	1097	28	R.	.25	+ .25	+ .25	═	90	90	H.	×
76			L.	.50	+ .50	+ .50	═	90	90	H.	×
77	1093	41	R.	.50	+ .50	+ .50	═	90	90	H.	×
78			L.	.25	..	+ .25	═	90	90	H.	×

[1] Axis against rule.

CLASS III.

No. of Eye.	Case Book No.	Age.	Right or Left Eye.	Astigmatism by Ophthalmometer.	Astigmatism by Retinoscopy.	Glass Prescribed.	Difference between Glass and Ophthalmometer.	Axis to Meridian of Least Curvature.	Axis of Glass Prescribed.	General Refraction of Eye.	Mydr. Employed Marked X.
1	7321	42	R.	.50	..	..	.50	90°	..	H.	..
2	7300	25	R.	.25	..	..	.25	90	..	H.	X
3			L.	.25	..	..	.25	90	..	H.	X
4	7288	25	R.	.25	..	..	.25	90	..	M.	..
5			L.	.25	..	..	.25	90	..	M.	..
6	7287	20	R.	.25	..	..	.25	90	..	E.	..
7			L.	.25	..	..	.25	90	..	E.	..
8	7255	67	R.	.25	..	..	.25	90	..	H.	..
9			L.	.50	..	..	.50	90	..	H.	..
10	7245	31	R.	.25	..	..	.25	90	..	H.	X
11	7244	..	R.	.25	..	..	.25	90	..	M.	..
12			L.	.50	..	..	.50	90	..	M.	..
13	7222	22	R.	.75	..	..	.75	90	..	H.	X
14	7218	52	L.	.25	..	..	.25	180	..	H.	..
15	7210	43	R.	.25	..	..	.25	90	..	H.	..
16	7195	66	R.	.25	..	..	.25	90	..	H.	..
17			L.	.25	..	..	.25	90	..	H.	..
18	7188	..	R.	.75	..	..	.75	90	..	H.	X
19	7179	65	R.	.75	..	..	.75	90	..	H.	..
20			L.	.75	..	..	.75	90	..	H.	..
21	7165	58	R.	.50	..	..	.50	90	..	H.	.
22			L.	.50	..	..	.50	90	..	H.	..
23	7163	38	R.	.25	..	..	.25	90	..	H.	X
24	7154	..	R.	.25	..	..	.25	90	..	H.	X
25	7154	..	L.	.75	..	..	.75	90	..	H.	X
26	7128	13	R.	.50	..	..	.50	90	..	H.	X
27	7125	60	R.	.25	..	..	.25	90	..	H.	..
28			L.	.25	..	..	.25	90	..	H.	..
29	7121	..	R.	.25	..	..	.25	90	..	H.	X
30	7120	7	R.	.25	..	..	.25	90	..	H.	X
31	7118	29	L.	.25	..	..	.25	180	..	E.	..
32	7115	19	R.	.25	..	..	.25	90	..	H.	X
33	7090	14	R.	.75	..	..	.75	90	..	H.	X
34			L.	.75	..	..	.75	100	..	H.	X
35	7089	40	R.	.25	..	..	.25	90	..	H.	X
36			L.	.25	..	..	.25	90	..	H.	X
37	7086	9	R.	.25	..	..	.25	90	..	H.	X
38	7079	40	R.	.75	..	..	.75	90	..	H.	..
39	7079	..	L.	.25	..	..	.25	90	..	H.	..

CLASS III.—*continued.*

No. of Eye.	Case Book No.	Age.	Right or Left Eye.	Astigmatism by Ophthalmometer.	Astigmatism by Retinoscopy.	Glass Prescribed.	Difference between Glass and Ophthalmometer.	Axis to Meridian of Least Curvature.	Axis of Glass Prescribed.	General Refraction of Eye.	Mydr. Employed Marked X.
40	7069	12	R.	1.00	..	..	1.00	90°	..	M.	×
41			L.	1.00	..	..	1.00	90	..	M.	×
42	7058	12	R.	.25	..	..	.25	90	..	H.	×
43			L.	.25	..	..	.25	90	..	H.	×
44	7054	19	R.	.25	..	..	.25	90	..	H.	×
45	7044	30	R.	.50	..	..	.50	90	..	H.	..
46			L.	.25	..	..	.25	90	..	H.	..
47	7335	52	L.	.75	..	..	.75	90	..	M.	..
48	7324	49	R.	.50	+ .25	+ .25	.25	90	90°	H.	..
49	7324	49	L.	.75	+ .50	+ .50	.25	90	90	H.	..
50	7323	16	R.	.50	+ .25	+ .25	.25	90	90	E.	..
51	7321	42	L.	1.50	+ .50	+ .50	1.00	90	90	H.[2]	..
[1]52	7320	68	R.	.50	+ .25	..	.50	180	..	H.	..
[1]53			L.	.50	+ .25	..	.50	180	..	H.	..
[1]54	7319	35	R.	.75	— .25	..	.75	90	..	M.	..
55			L.	.75	— .50	— .50	.25	90	180	M.	..
[1]56	7315	67	R.	.25	+ .25	..	.25	180	..	H.	..
[1]57			L.	.25	+ .25	..	.25	180	..	H.	..
58	7313	21	R.	1.25	+ .50	+ .50	.75	90	90	H.	..
59			L.	1.25	+ .50	+ .50	.75	90	90	H.	.
60	7311	24	R.	1.50	+1.00	+ .75	.75	75	80	E.	..
61			L.	1.00	+1.00	+ .75	.25	90	90	E.	..
62	7309	19	R.	1.00	+ .50	+ .50	.50	75	65	H.	..
63	7307	55	R.	1.50	+ .50	..	1.50	90	..	H.	..
64			L.	2.00	+ .50	..	2.00	90	..	H.	..
65	7305	33	L.	.50	+ .50	+ .25	.25	90	90	E.	..
[2]66	7303	20	R.	1.50	..	..	1.50	120	..	H.	..
[2]67			L.	1.50	..	..	1.50	105	..	H.	..
68	7302	23	R.	.75	+ .75	+ .50	.25	90	90	H.	×
69			L.	1.00	+1.00	+ .75	.25	90	90	H.	×
70	7294	..	R.	.50	+ .25	+ .25	.25	90	90	H.	..
71			L.	.50	+ .25	+ .25	.25	90	105	H.	..
72	7293	23	L.	.75	+ .75	+ .25	.50	90	90	H.	×
73	7290	18	L.	.75	+ .50	+ .50	.25	90	90	H.	×
74	7285	17	L.	4.50	+4.25	+4.00	.50	75	70	H.	×
75	7284	36	R.	1.00	+ .50	+ .50	.50	90	90	H.	×
76			L.	1.25	+ .75	+ .75	.50	90	90	H.	×
77	7283	11	R.	1.25	+1.00	+ .75	.50	90	90	H.	×
78			L.	1.25	+ .75	+ .75	.50	90	90	H.	×

[1] Retinoscopy indicated axis against the rule.

[2] Choroiditis and interstitial keratitis.

CLASS III.—*continued.*

No. of Eye.	Case Book No.	Age.	Right or Left Eye.	Astigmatism by Ophthalmometer.	Astigmatism by Retinoscopy.	Glass Prescribed.	Difference between Glass and Ophthalmometer.	Axis to Meridian of Least Curvature.	Axis of Glass Prescribed.	General Refraction of Eye.	Mydr. Employed Marked ×
79	7277	26	R.	.50	— .25	..	.50	90°	..	M.	..
80			L.	.50	— .25	..	.50	110	..	M.	..
81	7272	30	R.	.75	+ .25	+ .25	.50	90	90°	H.	..
82			L.	.50	+ .25	+ .25	.25	90	105	H.	..
83	7269	29	R.	.75	..	+ .25	.50	90	90	H.	..
84			L.	.75	+ .25	+ .50	.25	90	90	H.	..
85	7265	38	L.	5.00	+4.00	+4.00	1.00	90	90	H.	..
86	7261	39	R.	.75	+ .50	+ .50	.25	90	90	E.	..
87			L.	.75	+ .75	+ .50	.25	90	90	E.	..
88	7254	49	L.	.75	+ .25	+ .25	.50	105	105	H.	..
[1]89	7252	44	R.	.25	+ .25	..	.25	180	..	H.	..
90			L.	.25	+ .25	..	.25	180	..	H.	..
91	7248	12	R.	1.50	+ .25	..	1.50	90	..	H.	..
92			L.	1.50	+ .25	..	1.50	90	..	H.	..
[2]93	7247	14	R.	1.25	+ .75	+ .75	.50	105	105	H.	×
94			L.	1.00	+ .75	+ .50	.50	90	90	H.	×
95	7243	49	R.	1.25	..	+ .75	.50	180	170	H.	..
[1]96			L.	2.25	..	+ 1.25	1.00	180	5	H.	..
97	7240	..	R.	.25	+ .25	..	.25	90	..	H.	×
98			L.	.25	+ .25	..	.25	90	..	H.	×
[3]99	7239	69	R.	5.00	+5.00	+4.00	1.00	180	180	H.	..
100	7233	51	R.	1.00	+ .75	+ .75	.25	90	90	H.	..
101			L.	1.00	+ .75	+ .50	.50	90	90	H.	..
102	7226	24	L.	1.50	+1.00	+ .75	.75	90	90	H.	×
103	7225	30	R.	.75	+ .25	+ .25	.50	90	90	H.	×
104			L.	1.00	+ .50	+ .50	.50	90	90	H.	×
105	7222	22	L.	1.00	+ .25	+ .25	.75	90	90	H.	×
106	7220	..	L.	.50	+ .25	..	.50	90	..	M.	×
107	7217	37	L.	1.00	+ .75	+ .75	.25	90	90	H.	×
108	7215	17	R.	1.25	+ 1.25	+1.00	.25	90	90	H.	×
109			L.	1.25	+ 1.25	+1.00	.25	90	90	H.	×
[4]110	7213	32	R.	2.00	+2.00	..	2.00	90	..	H.	×
111			L.	1.25	+1.00	+1.00	.25	90	90	H.	×
112	7211	28	R.	1.00	+ .75	+ .75	.25	80	80	H.	×
113			L.	1.50	+1.25	+ 1.00	.50	95	95	H.	×
114	7207	36	R.	3.00	+3.00	+ 2.75	.25	75	85	H.	..
115			L.	2.75	+2.50	+ 2.50	.25	105	95	H.	..
116	7204	24	L.	.50	+ .25	+ .25	.25	90	90	H.	..
117	7202	14	L.	4.25	+4.50	+ 4.00	.25	100	100	H.	×

[1] Retinoscopy indicated axis against the rule.
[2] Converging strabismus with spasm of the ciliary muscle.
[3] After cataract extraction.
[4] Converging strabismus.

CLASS III.—*continued.*

No. of Eye.	Case Book No.	Age.	Right or Left Eye.	Astigmatism by Ophthalmometer.	Astigmatism by Retinoscopy.	Glass Prescribed.	Difference between Glass and Ophthalmometer.	Axis to Meridian of Least Curvature.	Axis of Glass Prescribed.	General Refraction of Eye.	Mydr. Employed Marked ×.
118	7199	14	L.	.75	+ .25	+ .25	.50	90°	90°	H.	×
119	7197	18	R.	1.50	+ .25	+ .25	1.25	90	90	H.	×
120			L.	1.50	+ .50	+ .50	1.00	90	90	H.	×
121	7192	..	R.	1.00	— .50	— .50	.50	120	60	M.	×
122	7190	16	R.	1.50	—1.50	—1.25	.25	20	115	M.	×
123	7185	..	R.	.50	+ .25	+ .25	.25	90	90	H.	×
124			L.	.50	+ .25	+ .25	.25	90	90	H.	×
125	7183	23	R.	1.00	— .75	— .75	.25	180	120	M.	..
126	7182	15	R.	1.00	+ .50	+ .50	.50	90	90	H.	×
127			L.	1.00	+ .50	+ .50	.50	90	90	H.	×
128	7177	30	R.	1.00	+ .25	..	1.00	90	..	H.	×
129	7175	37	L.	.25	— .25	..	.25	90	..	M.	..
130	7170	..	R.	.50	+ .50	..	.50	90	..	H.	..
131			L.	.25	+ .25	..	.25	90	..	H.	..
132	7169	9	R.	.75	+ .50	+ .50	.25	90	90	H.	×
133			L.	1.25	+ .50	+ .50	.75	90	90	H.	×
134	7164	65	R.	1.00	+ .50	..	1.00	90	..	H.	..
135	7153	50	R.	.75	+ .50	+ .50	.25	90	90	H.	×
136			L.	1.00	+1.00	+ .75	.25	90	90	H.	×
137	7140	..	R.	6.00	—5.00	—4.00	2.00	90	5	M.	×
138			L.	8.00	—7.00	—4.00	4.00	75	165	M.	×
139	7133	22	R.	.50	+ .25	..	.50	90	..	H.	×
140			L.	.50	+ .25	..	.50	90	..	H.	×
141	7132	27	L.	.75	— .50	— .50	.25	105	5	M.	×
142	7121	..	L.	.50	+ .25	+ .25	.25	90	90	H.	×
143	7120	7	L.	.50	+ .25	+ .25	.25	90	90	H.	×
[1]144	7116	14	R.	.75	+ .50	+ .50	.25	150	105	H.	×
[1]145	7116	14	L.	.75	+ .50	+ .50	.25	105	75	H.	×
146	7112	32	R.	5.00	—5.00	— 2.50	2.50	135	45	M.	×
147	7110	44	R.	1.00	+ .75	+ .75	.25	105	90	H.	..
148			L.	4.00	+4.00	+3.00	1.00	75	75	H.	..
149	7100	52	R.	.75	+ .75	+ .50	.75	90	90	H.	..
150			L.	.50	+ .25	+ .25	.25	90	120	H.	..
151	7099	38	R.	1.00	+ .75	+ .75	.25	90	90	H.	×
152	7098	26	R.	.75	+ .50	+ .50	.25	90	90	H.	×
153			L.	1.00	+ .75	+ .75	.25	90	90	H.	×
154	7092	21	L.	3.00	+2.50	+2.00	1.00	135	135	H.	×
[2]155	7082	72	L.	5.50	..	+4.50	1.00	160	150	H.	..
156	7078	10	R.	1.25	+1.00	+1.00	.25	90	90	H.	×

[1] Axis against rule.

[2] After cataract extraction.

CLASS III.—*continued.*

No. of Eye.	Case Book No.	Age.	Right or Left Eye.	Astigmatism by Ophthalmometer.	Astigmatism by Retinoscopy.	Glass Prescribed.	Difference between Glass and Ophthalmometer.	Axis to Meridian of Least Curvature.	Axis of Glass Prescribed.	General Refraction of Eye.	Mydr. Employed Marked ×
157			L.	1.00	+ .50	+ .50	.50	90°	90°	H.	×
158	7077	18	R.	.75	— .75	— .50	.25	90	180	M.	..
159	7072	24	R.	1.50	+1.00	+1.00	.50	90	90	H.	×
160			L.	1.50	+1.50	+ 1.25	.25	90	80	H.	×
161	7060	36	R.	.50	+ .25	+ .25	.25	90	90	E.	×
[7]162			L.	.50	+ .25	+ .25	.25	90	90	E.	×
[1]163	7327	25	R.	7.00	..	—4.00	3.00	90	180	M.	×
164			L.	3.00	..	— 2.75	.25	75	160	M.	×
165	7050	33	R.	1.00	+ .50	+ .50	.50	90	90	H.	×
166			L.	1.25	+1.50	+ .50	.75	90	80	H.	×
167	7048	..	R.	1.75	+1.00	+1.00	.75	90	90	M.	×
[2]168	7043	23	R.	.50	+ .25	+ .25	.25	90	180	H.	×
169	7043	23	L.	.75	+ .25	+ .25	.50	90	90	H.	×
170	7041	42	R.	3.00	+3.00	+2.50	.50	90	90	H.	..
171			L.	3.25	+3.50	+2.50	.75	90	80	H.	..
172	5066	42	R.	.50	+ .25	+ .25	.25	90	90	H.	×
[3]173	5065	61	L.	6.00	+6.00	+5.00	1.00	165	155	H.	..
[3]174	5059	78	R.	5.00	+5.00	+4.50	.50	10	10	H.	..
[4]175	5059	78	R.	1.50	+1.50	+1.50	..	10	10	..	..
[1]176	7334	23	L.	.75	+ .50	+ .50	.25	90	90	H.	..
177	7332	18	L.	.50	+ .50	+ .25	.25	90	90	H.	×
[2]178	7331	17	R.	.50	+ .25	+ .25	.25	90	180	H.	×
179	7285	17	R.	3.50	+4.00 — .50	+3.00 ..	.50	105	105	..	×
180	7258	23	R.	1.25	+ .50 — .25	.. + .50	.75	90	90	..	×
[6]181	7231	..	L.	2.50	+ .75 —1.00	+ .75 — 1.00	.75	90	90	..	×
182	7226	24	R.	2.00	+1.00 — .50	+ .50 — .50	1.00	90	105	..	×
183	7155	18	R.	3.00	+ .50 —2.00	+ .50 —1.50	1.00	90	90	..	×
184	7076	35	R.	2.00	+1.00 — .75	+ .75 — 1.00	.25	90	90	..	×
185	7051	..	R.	1.75	+ .50 —1.00	+ .50 — 1.00	.25	90	70	..	×
186	7332	18	R.	2.75	+2.50 — .75	+ 1.75 — .75	.25	90	90	..	×
[6]187	7318	20	R.	3.25	+3.00 — .50	.. + 3.00	.25	120	115	..	×

[1] Conical cornea.
[2] Axis against rule.
[3] After cataract extraction.
[4] Four months later.
[5] Marked ptosis.
[6] Slight leucoma.
[7] Conical cornea.

CLASS III.—*continued.*

No. of Eye.	Case Book No.	Age.	Right or Left Eye.	Astigmatism by Ophthalmometer.	Astigmatism by Retinoscopy.	Glass Prescribed.	Difference between Glass and Ophthalmometer.	Axis to Meridian of Least Curvature.	Axis of Glass Prescribed.	General Refraction of Eye.	Mydr. Employed Marked ×.
*188			L.	2.75	+2.00	+1.00	.75	85°	75°	..	×
					—1.00	—1.00					
189	7301	35	L.	2.00	+ .50	..	1.25	95	15	..	×
					— .75	— .75					
190	7337	29	R.	.50	+ .25	+ .25	.25	80	80	H.	..
191			L.	.50	+ .25	+ .25	.25	80	80	H.	..
192	6225	26	L.	1.50	+1.00	+1.25	.25	90	90	H.	×

CLASS IV.

No. of Eye.	Case Book No.	Age.	Right or Left Eye.	Astigmatism by Ophthalmometer.	Astigmatism by Retinoscopy.	Glass Prescribed.	Difference between Glass and Ophthalmometer.	Axis to Meridian of Least Curvature.	Axis of Glass Prescribed.	General Refraction of Eye.	Mydr. Employed Marked ×.
1	7278	12	R.	..	+ .25	+ .25	.25	..	90°	H.	×
2	7264	20	R.	..	+ .50	+ .50	.50	..	180	H.	×
3			L.	..	+ .25	+ .25	.25	..	160	H.	×
4	7236	..	R.	..	+ .25	+ .25	.25	..	105	H.	×
5	7183	23	L.	..	— .25	— .25	.25	..	180	M.	..
6	7168	19	R.	..	+ .25	+ .25	.25	..	95	H.	×
7			L.	..	+ .25	+ .25	.25	..	85	H.	×
8	7162	21	R.	..	+ .50	+ .75	.75	..	90	H.	×
9			L.	..	+ .25	+ .50	.50	..	90	H.	×
10	7149	37	R.	..	..	— .50	.50	..	115	M.	..
11			L.	..	..	— .50	.50	..	60	M.	..
12	7146	27	R.	..	+ .75	+ .75	.75	..	90	H.	×
13			L.	..	+ .50	+ .50	.50	..	90	H.	×
14	7130	30	L.	..	+ .50	+ .25	.25	..	90	H.	×
15	7127	..	R.	..	+ .50	+ .25	.25	..	90	H.	..
16	7122	23	R.	..	— .75	— .75	.75	..	90	M.	..
17			L.	..	— .50	— .50	.50	..	90	M.	..
18	7114	23	R.	..	+ .50	+ .50	.50	..	165	H.	×
19			L.	..	+ .50	+ .50	.50	..	15	H.	×
20	7092	21	R.	..	+ .50	+ .50	.50	..	30	H.	×
21	7202	14	R.	3.25	+4.25	+4.00	.75	80°	80	H.	×
22	7150	24	R.	.50	+1.25	+1.00	.50	90	90	H.	..
23			L.	.25	+1.23	+1.00	.75	90	90	H.	..

* Slight leucoma.

CLASS IV.—*continued.*

No. of Eye.	Case Book No.	Age.	Right or Left Eye.	Astigmatism by Ophthalmometer.	Astigmatism by Retinoscopy.	Glass Prescribed.	Difference between Glass and Ophthalmometer.	Axis to Meridian of Least Curvature.	Axis of Glass Prescribed.	General Refraction of Eye.	Mydr. Employed Marked ×.
24	7147	26	R.	.25	+ .75	+ .50	.25	90°	90°	H.	×
25	7147	26	L.	.25	+ .75	+ .50	.25	90	90	H.	×
26	7137	28	R.	.25	—1.00	—1.00	.75	90	180	M.	×
27			L.	.25	— 2.00	—1.50	1.25	90	180	M.	×
28	7127	..	L.	.25	+ .75	+ .50	.50	90	90	H.	×
29	7126	..	R.	.25	+ .50	+ .50	.25	90	90	H.	×
30	7124	..	R.	.25	+ .75	+ .50	.55	90	90	H.	×
31			L.	.25	+ .50	+ .50	.25	90	90	H.	×
32	7106	..	R.	.25	+ .50	.50	.25	90	105	H.	×
33			L.	.25	+ .50	+ .50	.25	90	75	H.	×
34	7104	28	R.	.25	+ .50	+ .50	.25	90	80	H.	×
35			L.	.25	+ .50	+ .50	.25	105	100	H.	×
36	7102	31	R.	.25	+ .50	+ .50	.25	90	90	H.	×
37			L.	.25	+ .50	+ .50	.25	90	90	H.	×
38	7052	43	L.	1.25	+2.00	+2.00	.75	180	180	H.	×
39	7336	27	L.	1.00	+ .50	+1.25	.25	180	180	H.	×
40	7209	49	R.	1.75	+ .50 —1.50	+ .50 —1.50	.25	90	90	..	×
41			L.	1.75	+ .50 — 1.50	+ .50 — 1.50	.25	90	90	..	×
42	7051	..	L.	1.75	+ 1.00 — 1.00	+ 1.00 — 1.00	.25	90	90	..	×
43	7336	27	R.	2.00	+ 2.50 — .50	+ 2.50 — .50	1.00	180	180	..	×

In Class I there are 155 eyes. This indicates that in thirty-one per cent. of the eyes examined no astigmatism was found by any test. The one interesting fact regarding Class I is the large number of patients (over one-half) past thirty-five years of age. This is in accord with universal experience that in the majority of patients who consult us for presbyopia, we find very little, if any, astigmatism. Homatropine was employed in one-fourth of the cases.

In class II there are 110 eyes. or twenty-two per cent. of the whole number examined, in which the ophthalmometer gave the same amount of astigmatism as the other tests. Homatropine was used in about four-fifths of this class.

Eyes 93, 96, and 108 were measured after cataract extraction. The ophthalmometer perfectly revealed the degree of astigmatism and the axis of the cylinder prescribed.

No. 44 is one of the most interesting cases recorded. The patient

had a large chalazion in the centre of the left upper lid, and she complained of marked eye strain. V. O. S. = $\frac{20}{70}$; ophthalmometer = + 3.00 D. 75° and 165°; retinoscopy = + 3.00 D^{c}., axis 75°. I prescribed + 3.00 D^{c}., axis 60°. This brought the vision up to $\frac{20}{20}$, and corrected the lines on the astigmatic dial. Three weeks after making this prescription, she concluded that she would have the chalazion removed. A few days after its removal she returned, saying that she could not see with her glasses, which formerly had given so good vision. Again I tested the eye; ophthalmometer = ± 1.25 D. 75°, and 165°; retinoscopy = + 1.25 D^{c}., axis 75°. I changed the glasses to + 1.25 D^{c}., axis 75° and V. = $\frac{20}{20}$. These she has worn for a year. I believe that the pressure exerted by the chalazion upon the globe increased the corneal curvature in the perpendicular meridian. This case shows at least one advantage of the instrument. It clearly revealed where the change in the refraction occurred—at the cornea.

Adding together Classes I and II there is a total of 265 eyes, or fifty-three per cent. in which the ophthalmometer perfectly corresponded with other tests. While this is a good showing for the instrument, it is not a sufficiently large per cent. to warrant one in prescribing glasses from it.

In Class III there are 192 eyes, or thirty-eight per cent. of all under observation, in which the ophthalmometer gave a greater amount of astigmatism than the other tests. A mydriatic was used in 106 eyes, (a little more than one-half.) In 99 eyes, or fifty per cent., the difference between the cylinder prescribed and the astigmatism noted by the ophthalmometer was .25 D.; in 43, .50 D.; in 23, .75 D.; in 15, 1.00 D.; in 2, 1.25 D.; in 5, 1.50 D.; in 2, 2.00 D.; in 1, 2.50 D. (No. 146 myopia 13 D.); in 1, 3.00 D. (No. 163, with conical cornea); and in 1, 4.00 D. (No. 38, myopia 12 D.)

In 47 eyes of this class, the ophthalmometer showed astigmatism; the other tests, none. In 29 of the 47, it indicated only .25 D.; in 7, .50 D.; in 9, .75 D.; and in 2, 1.00 D.

Mixed astigmatism was found in 11 eyes. Four eyes were examined after cataract extraction; 3 of which took a cylinder 1.00 D. less than the ophthalmometer indicated; and 1, .50 D. less.

In Class IV there are 43 eyes, or a little less than nine per cent. in which the ophthalmometer indicated less astigmatism than the other tests. A mydriatic was employed in 35 eyes. In 22 eyes the difference between the cylinder prescribed and the astigmatism noted by the ophthalmometer was .25 D.; in 11, .50 D.; in 7, .75 D.; in 1, 1.00 D.; and in 1, 1.25 D. In 20 eyes out of the 43 the ophthalmometer indi-

cated no astigmatism, but the other tests did ; and a cylinder was prescribed. Of the cylinders for the 20 eyes 8 were .25 D.; 9, .50 D.; and 3, .75 D. Mixed astigmatism occurred in four eyes, in 3 of which the ophthalmometer showed .25 D. less ; and in the other, 1.00 D less than the other tests.

In 265 eyes out of the 500 examined, the ophthalmometer corresponded with other tests ; in 121 it showed a difference of .25 D. from the cylinder prescribed ; in 54, a difference of .50 D.; in 30, a difference of .75 D.; in 16, a difference of 1.00 D. ; and in 14, a difference ranging from 1.25 D. to 4.00 D. A mydriatic was used in 259 eyes, or about one-half the number examined.

The axis of the cylinder prescribed agreed with the ophthalmometer in 94 eyes ; differed from 5 to 20 degrees in 54 eyes, and was against the rule in 13 eyes. The instrument is capable of more accurately indicating the axis than these figures indicate, but unnecessary time would be spent in adjusting the instrument in cases of slight astigmatism. The greater the astigmatism, the more rapidly and perfectly can the axis be secured. In less than three per cent. the axis of the cylinder was against the rule, as shown by the ophthalmometer.

Dr. Black, in the July ARCHIVES OF OPHTHALMOLOGY, p. 333, states that he finds fourteen per cent. against the rule.

Conclusion.—My experience with the ophthalmometer has led me to the following conclusions :

I. It correctly indicates in all cases the presence or absence of corneal astigmatism, the amount when present, and the meridians of greatest and least curvature.

II. It demonstrates that astigmatism is usually corneal, and that in a majority of eyes the cornea reveals the *total* astigmatism. It also as positively shows that the refraction may be astigmatic in an eye with a normally curved cornea, and that in all probability in such eyes the shape or position of the crystalline lens is the cause of it.

From the large number of eyes in which the subjective test indicated more or less astigmatism than the ophthalmometer, it would appear as though lenticular astigmatism was quite common. This I do not believe to be the case. It must be remembered that there were 121 eyes in which the difference was only .25 D., and fifty-four in which it was .50 D. Now it is a well appreciated fact that any two observers examining the same eye with the same tests are liable to find their respective results varying from .25 D. to .50 D., so that these slight differences are as liable to be the fault of the observer as of the instrument or method employed.

But there are other reasons for believing that lenticular astigmatism is rare. Dr. Burnett* has shown that the cornea gradually diminishes in curvature from the visual axis toward the periphery, and more often this diminution is greater in the horizontal meridian than in the vertical. On the average it amounts to 2.00 D. at 15° on the nasal side, and .50 D. on the temporal side. The ophthalmometer, however, measures the whole cornea and not simply that central portion used in ordinary vision where the difference between the perpendicular and horizontal meridians is least. The optical result of this would be that a patient would take a cylinder less than the ophthalmometer indicated. Experience has shown this to be the fact in a large per cent. of eyes examined. The same possibility of difference enters into eyes refracted with a dilated pupil. That the difference between the ophthalmometrical measurement and the glass prescribed is not caused by astigmatism in the lens, is further proved by the fact that after cataract extraction many patients cannot take the cylinder indicated by the ophthalmometer. See Class III., Nos. 99, 155, 174, and 175.

III. It shows that the tension of the lids influences the corneal curvature; that atropine and homatropine do not materially affect its curvature, and that tenotomy of the ocular muscles very rarely, if at all, changes the curvature of the cornea.

IV. It demonstrates that hyperopia and myopia are not usually due to changes at the cornea.

V. It is of great service in determining the *axis* of a cylinder for patients with amblyopia who cannot decide within five to twenty degrees the best position for it.

VI. It lessens the number of cases in which a mydriatic should be employed.

VII. It demonstrates to my satisfaction the utter uselessness of trying to reduce to a general rule the prescribing of astigmatic glasses.

To deduct from the ophthalmometrical measurement .25 D. or .50 D., as has been suggested, is radically wrong. It does an injustice to about fifty per cent. of the patients examined. Dr. Story† of Dublin found that in 62 eyes out of 139 the ophthalmometer indicated the same amount of astigmatism as the other tests.

In prescribing astigmatic glasses each case must be individualized. The ophthalmometer is a scientific instrument revealing certain facts

*American Journal of Ophthalmology, vol. ix, p. 228.
†Ophthalmic Review, vol. x. p, 195.

regarding the cornea that no other instrument furnishes, but its chief sphere of usefulness is to quickly indicate the line of investigation which must be followed in refraction work. To this extent the instrument is invaluable.

DISCUSSION.

CHAS. DEADY: I agree with the writer that Javal's ophthalmometer is a scientific instrument. We have several means of ascertaining the refraction of any given case. We take the patient, sit him beside the test card, find out what his vision is and what glasses will correct that vision. That gives us the vision, as it is, without regard to any spasm of accommodation or any other factor. It is unreliable for prescribing glasses. Another method is retinoscopy, which consists in judging of the refraction of an eye by the shadows which are cast in the eye by the ophthalmoscope. This has been proven to be inaccurate in a large number of cases. Perhaps the most accurate method of ascertaining the refraction aside from the use of mydriatics is the direct ophthalmoscopic examination; but even this in the hands of the most expert is insufficient to satisfy us as to exactly what glass any given patient requires. In the hands of Hermann Knapp of New York, who is perhaps the ablest in the United States in the use of the ophthalmoscope, it has been proven insufficient several times to my knowledge. Then we have the use of mydriatics and when I say that I do not mean homatropine or cocaine. Homatropine is insufficient; it will not paralyze the accommodation, and cocaine acts still less on the ciliary muscle.

We have three preparations, either of which will absolutely paralyze the accommodation, after a sufficient use, and by that I do not mean two hours use in the physician's office. But anywhere from two to three days use, the application to be made once a day. After an examination made under these conditions, in most cases we are certain that we have the accommodation absolutely paralyzed and consequently that our glass is correct. The exceptions are in the cases of extreme myopia where the eyes have been over used and we have a spasm which will not yield to the most powerful mydriatic. I have seen cases where atropine for about three weeks was not sufficient to enable us to say absolutely what glass the patient required.

The ophthalmometer will show, as Dr. Bissell claims, within a very

small fraction exactly what the refraction is, but it will not show what glass that patient can wear. I do not think that any case of refraction can ever be said to be examined sufficiently accurately to prescribe the right glasses unless we use atropine, duboisine or hyoscyamine, and if we use these no other is necessary. Consequently I regard the ophthalmometer, except for purposes of scientific measurement as simply a waste of time in the private office.

DR. BISSELL: Without going into the question of mydriatics, the time spent by examining the patient with the ophthalmometer will not average over three minutes. The point I make is that it selects the cases in which it is necessary to use mydriatics and those in which they can be dispensed with. I have found it invaluable. It does not reveal the refraction; it is merely an instrument for detecting astigmatism, and to that extent it certainly is useful.

DR. DEADY: I do not wish to question Dr. Bissell's claims in regard to the ophthalmometer, but in his paper he states that in the lower degrees of astigmatism it takes longer to use this instrument and these are just the most troublesome to the patient and the most important to correct. In the greater amount of astigmatism I feel that we do not really need an ophthalmometer.

DR. BISSELL: The Doctor misunderstands me. What takes so much time to determine is the axis not the presence or amount of astigmatism.

REFLEX NEUROSES FROM EYE-STRAIN.

A. B. NORTON, M. D.

NEW YORK.

It has been my intention for some while to make a study of the various reflex conditions that may originate from some ocular defects, but owing to lack of time, have been unable to consider the subject now with that thoroughness which it merits and which I shall hope to give it on some future occasion.

This then may be considered as merely a preliminary paper, in which I shall simply detail a few interesting cases that were relieved after correction of the eye-strain, or at least certain defects of the eyes were

found and corrected without remedial or other treatment and the reflex trouble disappeared. Further these are not detailed to convey the idea that all diseases that flesh is heir to are the result of eye-strain for I certainly recognize the importance of various other organs in the causation of numerous reflex disturbances. It is, however, my purpose to call attention to the fact that the eye may be the disturbing element in various peculiar or obscure cases in hopes by so doing to incite further study of the eye as a cause of reflex disorders.

CASE I. Mr. L., age 26, was referred to me by Dr. R. Oliver Phillips on August 7, 1890, and gave the following history. Eight years previous his eyes had seemed to trouble him some and he had then consulted a prominent oculist, who had prescribed glasses, which he says he could not wear with comfort and in consequence had discontinued their use. Has occasional severe headaches in the temples which he thinks are neuralgic and due to bad teeth. The eyes become tired with some blurring of the vision and letters ran together on reading for an hour or more. Is very nervous and has frequent twitchings of the face. Mr. L. had on several occasions disappeared from his home and business for several weeks at a time without any apparent cause or reason. When again communicating with his family, or found by them, it might be in a different part of his country and at a great distance from his home. On questioning him as to his doings during his period of absence, or his reasons for going away in this manner, he either could not or would not assign any reason for the same and claimed to have no knowledge of where he had been or what he had been doing during the interval between the time of leaving and the time of coming to his senses again and would communicate with his family which on some occasions had extended over several weeks. It was for these peculiar attacks that he consulted Dr. Phillips, who before commencing any treatment for his case sent him to me to determine if any possible reflex condition of the eyes was creating the disturbance.

Upon examination I found a slight blepharitis. The vision was $\frac{1}{1}$ in each eye but with a convex .25 D. cyl. ax. 90° the astigmatic lines were made correct and the vision $\frac{1}{1}$ but a shade clearer. Under atropine the astigmatism was found to be the same and with 1. D. of hypermetropia. On August 19th, convex .25 D. cyl. ax. 90° was prescribed for each eye to be worn constantly.

I saw or heard nothing more from Mr. L. until June 9, 1892, when he called upon me with his wife to have her eyes examined. He then reported that he had worn his glasses constantly, that he had been in better health than ever before, had had no trouble with his head what-

ever and had made none of his mysterious disappearances since using his glasses.

Remarks. Mr. L. has thus gone for two years with no trouble whatever and has received no treatment at any time excepting a .25 D. cyl. glass.

CASE II. S. H ———, age 13, was sent to me by Dr. L. A. Opdyke, who considered the case one of epileptiform seizures and to whom I am indebted for the following history of the case. The boy would first complain of an intense nervous condition, head becoming full and dizzy and he would then soon become unconscious, some twitching and frothing at the mouth, biting the tongue but not severe. The attacks lasting from fifteen to thirty minutes, when over them, he was sleepy and entirely ignorant of anything following the dizzy feelings. His stomach would be out of order and he would feel generally weak and tired out for two or three days afterwards. These attacks came every 28 days for several months and then every three and finally every two weeks. We considered the cause to be his stomach at first but were often at a loss to find any indiscretion in diet, then from over study as he was a hard student, so took him from school without much benefit, but would say that he read books and practiced music and used his eyes even more than when in school. He had one or two attacks on the street when shopping with his mother. What did I do for him? Well, everything, I ever heard of, after going through the usual and unusual list of homœopathic remedies, I started in on bromides, which I pushed until the rash stopped me, would wait a few days and then try again. Gave him antifebrin 15 grs. a day so his lips were slightly blue all the time, this was kept up for two months. Finally, I circumcised him and thought I had hit it as he was having them every two weeks but as the sixth week came around he had another attack, and was soon having them as frequently as ever.

When first seen by me the boy was so extremely nervous and frightened that no satisfactory examination could be made at that time. On January 10th, 1891, he was brought to me again and after examination under atropine, compound hyperopic astigmatism was found, and the following prescription given for constant use R+.50 D.⊃+.50 D. cyl. ax. 90° O. D.; +1.25 D.⊃+.50 D. cyl. ax. 90° O. S.

August 4th, 1892, he called again with the report that he had had no attack whatever from the last date until one week ago, when he had had one attack of much shorter duration than the old ones and of less severity. At this time his glasses were increased to + 1. D.⊃+ 1. D. cyl. ax. 90° O. D. and + 1.25 D.⊃+ 1. D. cyl. ax. 90° O. S.

Remarks. This boy was having epileptiform seizures as frequently as every two weeks, the longest recent interval having been six weeks, varied treatment had been given him with no relief. After the use of glasses he had been 18 months with no attack, when one recurred and it was found he required an increase in the strength of his glasses.

CASE III. Sept. 30th, 1891, Mr. P———, age 31, occupation bank clerk was referred to me by Dr. Boocock with the following history. Has worn glasses about 13 years and the present ones one year. Has no headaches but a constant drawing sensation all through the head and especially in the forehead. An intense burning pain in the left eye all the time. Has a feeling as though there was a cover on top of his head and it did not fit well. These symptoms are all aggravated on any use of the eyes and on thinking. Has a great dread of light with almost constant winking of the eyes and twitching of the muscles of the face. Could not use his eyes for reading five minutes at a time. The twitching of the muscles of the face was first noticed about three weeks ago while writing at his desk, twitching of the muscles of the body followed and he then fell from his chair unconscious with frothing at the mouth, lips and face of a dark purple hue. The attack passing off in a few minutes leaving him very pale and weak. Has had several similar attacks since then. The attacks are preceded by an exceedingly short aura, he having barely time to break a capsule of amyl nitrite which he carried for the purpose, he described the aura as a sense of oppression of the chest and a choking in the throat. Three days previous to his visit to me he had consulted a prominent oculist of this city who told him that he had epilepsy, due to strain upon the muscles of the eye, gave him prisms to wear for a few days to develop all the latent esophoria possible and was to go to him the following day for operation.

Examination of his refraction under atropine showed a total hypermetropia of + 2. D., O. D., and +2.50 D., O. S., giving vision of $\frac{1}{1^{+}}$ in each eye. He was wearing for constant use the glass which corrected his total hypermetropia. The test of the muscles showed esophoria of 5° in the distance and 12° in accommodation. While under atropine he had frequent recurrence of his attacks, which weakened and frightened him so much that he was under the constant care of his old school physician, and did not return to me until Nov. 17th, at this time he was if anything decidedly worse than when first seen, in fact so excessively nervous that the examination was most unsatisfactory. I, however, prescribed for him +2.D.,⊂1½° prism base out O. D. +2.50. D., 1½° prism base out O. S. for constant use, and judged that these glasses very nearly

corrected his esophoria in distance. He was also ordered to follow Dyer's method of systematic reading.

On April 25th, 1892, Mr. P—— was again seen and reported having had but one attack, and that on April 4th since wearing the glasses ordered, five months before that he could read upwards of one hour without discomfort and was feeling much better every way. At this time a left hyperphoria of 1° was found and the esophoria with his glasses of less than 1°. A prism of 1½° base down before the left was added to his previous glasses for constant use. As he now complained of some numbness and stiffness of the tongue and side of face with similar sensations in the left leg he was referred to Dr. W. H. King, for diagnosis and opinion as to the use of electricity. Dr. King diagnosed the case as one of epilepsy and located the trouble in the deeper parts of the anterior portion of the parietal lobe posterior to the fissure of Rolando, and judged that the lesion was an inflammatory trouble concomitant with an attack of La Grippe (which he had had some time previous to his first visit to me). The use of electricity he thought would be of no especial value at present.

Mr. P—— again called on me at my request Oct. 3d and I learn that in July he again consulted the oculist whom he had seen before coming to me and is still under his care. He says that six operations have already been made and still there are more to follow. He is now wearing simple convex glasses with no prism correction and on testing his muscles there is still a left hyperphoria of 1° orthophoria in distance and an exophoria in accommodation of 10°. As to his general condition he is certainly improved, has less nervousness and fear of his old attacks which have not returned. He, however, still complains of the numbness of the tongue and that the left side of his body is not right yet. The burning in his eye which was always a prominent symptom still continues and his head still troubles him. He has had no use of his eyes for reading by order of his oculist, and an examination shows a decided limitation in the inward movement of his eyes.

Remarks. This case was undoubtedly of an epileptiform nature, with very frequent seizures, which entirely disappeared for five months after the use of prisms to restore the equilibrium of the lateral muscles. Then there occurred another slight attack at which time the hyperphoria became manifest and after correction there has been no further attack up to the present time, six months, making in all nearly eleven months with but one slight seizure. It seems, therefore, reasonable to conclude that in this caseat least the trouble was due to the eye-strain. As to the treatment by the two entirely different methods; he was

given by prisms entire relief for five months, then a slight attack, when a change of prisms gave a further relief for three months, or up to the time when the cutting was commenced. For the last three months he has been under the operative treatment with still no recurrence of his attacks. He is certainly better generally than when the cutting began, but as he was steadily improving before the operations, from wearing the prisms alone, who can say that he would not have gained fully as much if not more by this time without the operations. He had but one attack during the eight months of wearing the prisms, his general condition was steadily improving and he was using his eyes for reading upwards of one hour without discomfort. During the last three months he has undergone six operations, been denied the use of his eyes for reading, but has continued to improve generally and has discarded the prisms. All the practical gain so far seems to me to be in simply the fact that he is not wearing the prisms, but as these were combined with the glasses he had worn for years, and as he is still wearing and always will have to use glasses there was no additional annoyance or discomfort from the addition of the prisms. Again, my last examination three days ago showed an over cor rection of 10° in accommodation with a decided limitation in the power of the muscles. Now what will be the *ultimate* results six months or a year hence from cicatricial contraction after so many operations upon the delicate muscles of the eye? My experience leads me to believe that there will result an exophoria in accommodation with much trouble from inability to use the eyes and which will be due to over cutting. I do not wish to be understood as opposing all operations for heterophoria as I frequently make them myself, but *only* after all other measures have first been tried without relief. In this individual case I do not deny but that the operation was justifiable, but am afraid more has been done than is necessary.

CASE IV. Mrs. L. ———, age 30. Referred to me December 18, 1891, by Dr. R. Oliver Phillips because of attacks of vertigo, which commenced about seven years before. There had been a steadily increasing frequency in these attacks, so that of late they would come on every two or three days, and each attack lasting from one to two hours. When these attacks of dizziness come on she has to at once either sit or lie down, no matter where she is, if not she says that she would fall. There is often nausea or even vomiting with the attack and when they pass off leave her very weak and trembling. She had been under treatment with several physicians with no relief whatever and had then consulted Dr. Phillips, who refused to treat her until she

had had her eyes examined. She says she has no trouble with her eyes but admits that they feel some tired after reading for two hours or more. Has no headaches, whatever, and does not appear or admit of being at all nervous. Examination showed the vision to be $\frac{11}{11}$ in each eye but improved and lines made correct with + .25 D. cylinder axis 90° in each eye. Test of the muscles gave a left hyperphoria of 1° and an exophoria in accommodation of 7°. The following glasses were ordered to be worn constantly. R. + .25 D. cyl. ax. 90 ⌒ $\frac{1}{2}$° prism base up O. D., + .25 D. cyl. ax. 90 ⌒ $\frac{1}{2}$° prism base down O. S.

Mrs. L. writes me under date of Sept. 17, '92 (nine months after the only time she was seen by me), as follows: "I answer your inquiry concerning my dizzy attack with pleasure, as they seem to be permanently cured by the glasses. I still wear the glasses as my eyes feel much more comfortable with them on. Only twice have I had the dizziness return, and the first time was after going away for a day's visit and forgetting to wear them; the second time I had grown careless about putting them on in the morning, would be ten or eleven o'clock before I put them on, after about a week of such carelessness I had another attack which has cured me of carelessness so far as my glasses are concerned. My health is better than it had been for three or four years and I do honestly think that Dr. Phillips was right when he told me to have my eyes attended to and my physical, moral and spiritual being would be benefited."

Remarks. This case received absolutely no treatment excepting the wearing of a .25 D. cylinder glass with a $\frac{1}{2}$° prism in each eye.

CASE V. Miss P———, age 29, a patient of Dr. McMurray's consulted me Dec. 18, 1891, for a dull heavy headache and a tired, strained feeling in the eyes on using them. Is unable to use the eyes for reading more than 15 or 20 minutes at a time. Has suffered for a long time from nervous dyspepsia. Examination showed the vision to be $\frac{11}{11}$ in each eye with no manifest hypermetropia or astigmatism. Test of the muscles revealed an exophoria of 2° at distance and 6° in accommodation. The internal recti could only overcome prisms of 14° in each eye. Systematic exercise of the muscles was followed out until she could overcome prisms of 70° in each eye, when she could use her eyes with perfect comfort for hours, had no headaches, and her dyspepsia was better than it had been before in years.

Remarks. Miss P——— received no medicinal treatment and has been ordered no glasses to wear while under my care, she made no change in her mode of living but her dyspepsia of years improved with her eyes.

CASE VI. Mr. M———, age 32, occupation traveling salesman, also a patient of Dr. Phillips was sent to me on March 21, 1892, for insomnia which had troubled him greatly for the past year or more. He says that for three or four nights in succession he will be unable to sleep hardly any, then for a few nights he will seem to catch up somewhat to be followed again by several nights of sleeplessness. He had tried many different things for his trouble with no benefit before consulting Dr. Phillips who immediately sent him to me. He had not realized that he had any trouble whatever with his eyes, but thought perhaps they did feel tired some at times. Does not have headaches and could trace no connection between his sleeplessness and any unusual use of his eyes. Vision was found to be $\frac{1}{1}\frac{1}{5}$ with slight difficulty +.50 D. cyl. ax. 90° vision was made $\frac{1}{1}\frac{1}{5}$ in each eye and lines correct. Examination of the muscles gave left hyperphoria of $1\frac{1}{2}°$ esophoria of 2° at distance and 3° in accommodation. The following glasses were ordered to be worn constantly +.50 D. cyl. ax. 90° ⌣ $\frac{1}{2}°$ prism base up, O. D., + .50 D. cyl. ax. 90° ⌣ $\frac{1}{2}°$ prism base down O. S.

On July 22, I learned from the brother of Mr. M——— that he had had no further trouble in sleeping since wearing the glasses.

SENEGA IN THE TREATMENT OF HYPERPHORIA AND ITS RESULTANT SYMPTOMS.

E. H. LINNELL, M. D.,

NORWICH, CONN.

Since reading an article published in the *Journal of Ophthalmology, Otology, and Laryngology* for April, 1889, by the late Dr. George S. Norton, in which he suggested senega as a valuable remedy in the treatment of weakness or paralysis of the ocular muscles, and especially, of hyperphoria, I have used it extensively in my practice. I have lately been making a critical analysis of cases in which I have prescribed it, with a view of verifying its pathogenetic symptoms and arriving at more exact indications for its employment, and of bringing again to the notice of the profession a remedy which is worthy of more general employment. Although I refer especially to hyperphoria in the present paper, senega is also of value in other varieties of heterophoria and in

eye strain and from errors of refraction. I have selected from my clinical records seventeen cases as illustrating its sphere of usefulness, including some where it was not markedly beneficial. In nearly all of them Es. or Ex., or both, existed in connection with hyperphoria. They would be much more valuable had they all been treated by the remedy alone without other means, but I hope to be able to substantiate the claims made for it by Dr. Norton and to demonstrate conclusively that in senega we have a very valuable remedy for the cure of deviating tendencies of the eyes in a vertical direction, and for the relief of the distressing symptoms arising from such a cause. I have endeavored to point out specific subjective indications for its use, but in the absence of definite indications for this or some other remedy, the objective symptom of hyperphoria alone determines its prescription and usually with gratifying results. I believe the tendency is too strong to treat such cases by tenotomy, and I am satisfied that the method of treatment outlined in the subjoined cases will cure the majority, or if it does not radically cure them it will relieve the annoying symptoms and give better satisfaction both to the physician and the patient than the indiscriminate cutting of tendons that is advocated by some oculists. Of course there is a small minority of cases where tenotomy is indicated, but in the course of quite an extended experience I have met with very few where I considered it advisable. If this paper shall encourage a similar opinion in others and a more persevering trial of systematic exercise in connection with suitable remedies, holding tenotomy as a *dernier resort*, I shall be gratified.

CASE I. L. A., aged seventeen, a student. Hypermetropia; complains of pain and blurring of vision after moderate use of eyes. Conjunctivitis with smarting in lids. Plus 48° for near work relieved her. One year later she returned, saying her eyes had been much better, but that she had lately been studying hard and that her eyes were again painful. Refraction was the same as before. The phorometer now showed Ex. ½° and in accom. 6½°, R. int. 12°, L. int. 16°, each ext. 12°. The same glasses were continued and systematic exercise with prisms and faradism was used. She was discharged in two weeks with each int. overcoming a prism of 30° easily. She returned in six months saying her eyes had been all right until recently, when, after some use, she had again asthenopic symptoms. Now examination showed Rh. ½°, Ex. 1½°, and in accom. 3°, R. int. 30°, L. int. 32°. Systematic exercise for the vertical as well as int. recti was again practiced; together with faradism and senega 1x. In ten days she had orthophoria far and near with convergence of 60° and no asthenopia, and has had no relapse after more than a year.

CASE II. Mrs. M., middle age. Myopic astigmatism with Pr. Complains of pain back of eyes and in temples and considerable lachrymation, all < by use. Nat. mur., and correction of refraction produced considerable improvement, but pain in right eye soon returned and examination showed Rh. 1°. Senega 6x was given with prompt relief. Six months later she reported that her eyes had given her no further trouble. No examination was made.

CASE III. Hyperopic astigmatism; Lh. 5°, Es. 2°. Constant diplopia. Always subject to frequent headaches < by fatigue or excitement. Weight in occiput, pain in left eye, heaviness of lids, and drowsiness. Diplopia intermittently for a year, last few weeks constant, and headaches more frequent. Prescribed gels. 6x every three hours and exercise of ext. Right eye stands too low and turns in; has diplopia to the right of middle line. In ten days her head was better, there was no esophoria, and left hyperphoria was 3°. Continued treatment. After another week diplopia was less troublesome, but Lh. was again 5°. Gels. 1x. After ten days more Lh—4°; after exercise with prisms in office 2°. ℞ senega 6x and wear prism 2° base down, left eye, to partially correct the hyperphoria and give incentive to overcome it. After one week returned with improvement in headache and not much diplopia. Continued senega and wear prism only occasionally when diplopia is specially annoying. After two weeks head continued better and diplopia disappeared, but hyperphoria remained 3°. Could be temporarily reduced to 1° by practice with prisms in the office. ℞ rhus and wear prisms constantly. Tenotomy was advised and declined. This treatment gave great relief, and hyperphoria (manifest) was never more than 3° and did not increase under the use of a partially correcting prism. The use of the prisms was discontinued after two months and the headache and diplopia returned after a few days, but hyperphoria remained 3°. The use of the prism again promptly relieved the headache and diplopia without medicine. One year later she reported that she had only had occasional headaches. She did not wear glasses in the house, but was obliged to do so when out of doors. The phorometer now showed Lh. only 1½°. A hyperopic astigmatism of .25 D. was now corrected (it had not been previously, because she declined to use atropia) and these lens were worn constantly, combined with a prism of 1½° base down, left eye. She had very little trouble for a year, when the eyes again became painful and Lh. was 2½°. The same glasses were continued, but a pair of spectacles with prism 2° base down, right eye, and 1° base up, left eye, were given to be worn daily for an hour or more for practice.

After two weeks Lh. was the same; prisms were discontinued for practice and senega 1x 2 gtt. four times daily prescribed. This prescription relieved her so that she did not return for eight months. She then complained of confused vision and vertigo when turning her head, while lying down, or on getting up or when stooping. Lh—2°, refraction the same; no lateral deviation far or near. Wear prism 2° with cylinders constantly and take conium. She has not been seen since June 7, 1892.

CASE IV. Hyper-esophoria. Much headache < by use of eyes. Nervous prostration. Rh. 3°, Es. 6°. Plus 18ˢ for near work. Faradism, practice with prisms, and senega cured. Treatment was irregular, hence longer than usual. Finally orthophoria far and near and no asthenopia.

CASE V. One of Dr. Stevens' cases, upon whom he twice made tenotomy without benefit. He wished to operate twice more, but the patient declined and consulted me. He never remembers when his head did not ache. Pain in the occiput and behind the eyes; very nervous. He had compound hypermetropic astigmatism. The muscular condition varied greatly at different examinations, showing much unsteadiness of the muscles. Suitable glasses together with onosmodium, arg. nit., conium, or nux, as indicated, gave him great relief. Some months later the phorometer demonstrated Lh. 4°, Es. 2°, Ex. in accom. 5°. Under the use of senega 6x and systematic exercise, in one week hyperphoria was only 1°, Es. less than 1°, but Ex. in accom. 6°. He was under treatment for a considerable time. Senega was discontinued, and under onos. and systematic exercise the hyperphoria entirely disappeared, also the Ex. in accom. Es. ½° remained at last examination, nearly a year ago. He was then using his eyes nearly all day, and sometimes half the night, without discomfort. In this case senega was not of much benefit, because not well indicated, but the case is of interest as showing the results to be obtained by exercise and remedies in a severe case after tenotomy had been tried without benefit.

CASE VI. M. Am. Frequent headaches; eyes tire easily. R.—3.00 Dˢ., ⊂—.50 Dᶜ., ax. 90° O. D. and same ax. 60° O. S. gives relief, aided by phos. and, later, mellilotus. Three months later headache returned and was not relieved by remedies. Examination with phorometer now showed Lh. 5°, Es. 10°, Ex. in accom. 2°. After one month's treatment with prisms and electricity she had orthophoria far and near. Adduction = 52°, sursumduction = 4°, and she was free from headache. She has remained well ever since, now eighteen

months, going to school and using her eyes freely. Senega was used in this case for only about four days and without perceptible improvement. No medicine was taken during most of the time she was under treatment.

CASE VII. M. Am. Lh. 2½°, Es. 2°. Chronic headache, severe pain (not accurately described) after using eyes. My usual treatment with prisms and electricity was instituted and without internal medication at first. Later she complained of pain in the occiput and left side of head, for which she received onosmodium 3x. For two months she had no severe headache, then the phorometer showed Lh. 1°. She complained of tension over the eyes after near work for a short time, and I prescribed arg. met. 2c. Treatment with prisms was continued at her home, and three months later she wrote that her eyes were much better and that adduction was 52° with each eye. Ten days later I had an opportunity of examining her, and found orthophoria far and near. She again called at the office, after three months, and reported that she used her eyes pretty well and had had no severe headache but overuse caused pain in the temples. She then had Lh. 1°, Ex. in accom. ½°, adduction—60°, abduction R.—8°, L.—10°, sursumduction —4°. ℞ senega. The next day there was no hyperphoria, and Ex. in accom. was 4°. That was in December, 1890. I have not seen her since; but, in response to a letter addressed to her since commencing this paper, she wrote me that she very rarely had a headache, and for a long time had been able to use her eyes freely without discomfort.

CASE VIII. H. Ah. Lh. 8° Glasses given to correct the error of refraction were comfortable for reading, but the nearly constant headache, from which he had suffered for a long time, continued and was aggravated by the use of the eyes. He had pain over the eyes and a pressing-out sensation in both temples. I prescribed senega 6x. In five days Lh. was less than 1°, but the headache was no better. Adduction—16°, abduction—6° O. U. Continued senega with no other treatment. In five days more his headache was better, and Lh. was the same. Three weeks later the headache continued and was then more severe in occiput. Lh —1°, slight Ex. I then gave him a prism of 1° base down O. S. in combination with the cylinders previously prescribed, and mellilotus 1x. He was without glasses nine days, and then presented with more severe headache. He complained of pressure over each eye and much photophobia. Conium 6x was prescribed, and one week later he reported his "head better and glasses fine." Ten days afterward the head continued bettter, but Lh. was 2° and Ex. 1°. Galvanism was used once and conium continued. One week later Lh. was again

reduced to 1°, and Ex. 1°, but the headache was more severe. Conium 30x was given him, and two weeks later he was free from headache. The remedy was continued, and after three weeks he reported slight return of headache; could use his eyes half an hour at a time. More than that caused pain in the supraorbital region, and feeling as of sticks in the eyes. He had orthophoria far and near with his glasses. ℞ nat. mur. Six months later he was about the same; Lh. 1° with his spectacles. He was not seen again for two years, and during this time his eyes had been pretty comfortable, though not very strong. He had been free from headache, except after overuse of eyes. Without his glasses the phorometer showed Lh. 1½°, Ex. 1½°.

CASE IX. H. Ah. Lh. ½°, Ex. 2½°. Orthophoria in accom. Severe neurasthenia and general debility. She had never been able to use her eyes with comfort. She had much pain in occiput, extending down between her shoulders; pain and strained feeling in her eyes. She lived out of town and there was no opportunity for systematic exercise. Cim. gave some relief. Glasses were given to correct the error of refraction, but she did not use them with comfort and complained of nausea after near work for a short time. Jab. was given for these symptoms. After three months, during which she had worn her glasses intermittently, she complained of pain and soreness in her right eye and in the head and occiput on the right side. ℞ senega 1x. After six weeks, reports: "I wear my glasses constantly, and feel that I could not get along without them. I am nearly free from headache and use my eyes freely." Senega 6x. Lh. still ½°, Ex. in accom. 8°.

CASE X. Bookkeeper. Hm. Lh. ½°, Es. 1°, Ex. in accom. 1°. ℞ +60° for near work and senega. One year later no hyperphoria; Es. 3°, orthophoria in accom.

CASE XI. Miss F., age seventeen, student. Am. Rh. ½°, Ex. in accom. 1½°. Slight asthenopia and occasional headaches after using eyes. ℞ senega 6x and systematic exercise. In one month uses eyes with much more comfort. Rh. still ½°, Ex. in accom. 1°. Senega 1x. After three weeks orthophoria far and near and uses eyes without slightest discomfort. Three months later the same.

CASE XII. Spasm of accom. Apparent Am. After atropia H. O. D., H. Ah. O. S. Rh. Ex. in accom. Chronic headaches. Never free from pain in head and eyes. Dull pain in eyeballs. Eyes feel strained and lids heavy. Photophobia and dull pain in whole head. Hyperæmia of retinæ, especially left; disks blurry. The muscular condition was not accurately tested. Glasses for constant use. Onos., physostigma, and spig. relieved her so that she was free from headache for

two years. A slight change in glasses and onos. cured her again for four years. She again came under treatment in January, 1892. Refraction then was as previously. Within the last two weeks, for the first time in four years, she has had pain in the back and left side of her head. She was very nervous and had also much pain in the small of her back. Rh. = 1°. Ex. in accom. 12°, all verticals = 2°. ℞ onos., electricity and practice with prisms. In two days she was free from headache. After eight days Rh. ½°, Ex. in accom. same. Senega 6x was now prescribed and exercise continued. After nine days more Rh. same. Ex. in accom. 8°. Senega 1x. In another week no hyperphoria (she wore vertically refracting prisms each day at home during this week), but more headache. Senega 6x. After three weeks she reported: "No headache and able to use my eyes freely." Ex. in accom. 7°; continued treatment. After four days more Ex. in accom. 3½°; discontinue use of vertical prisms and wear 8° base out O. U. half an hour daily. Continued senega 6x. After four days again Rh. ¾°; orthophoria near. Now use both vertical and lateral prisms. In ten days Rh. ½°; orthophoria near. Continue prisms and take senega 1x. In eight days a good deal of headache, but orthophoria far and near. Each int.=32°. Senega 6x. Two weeks later orthophoria far and near. Discharged and when last heard from continued all right.

CASE XIII. Lawyer. Myopic astigmatism. Frequent headaches from eye strain, relieved by glasses and remedies. Was treated at intervals for several years. Never had unrestrained use of eyes. Onos. was frequently helpful. June 27, 1890, my record reads: Rh. 1°, Ex. 2°, in accom. 4°. ℞ onos. and galvanism. In three days he had orthophoria far and near. Treatment was continued at irregular intervals for one month, when each int.=30° instead of 10° and 14°, as at first. Then he was discharged with senega 6x. After one month, during which he was off on a vacation and eyes were pretty comfortable, he still had orthophoria, but a latent Rh. was suspected. Treatment with prisms and galvanism was resumed and senega continued some weeks until all verticals = 4° and the eyes were used comfortably. He came again March 30, 1891, with Rh. ½° Ex. ½°, Ex. in accom. 2°. Agaricus was prescribed, and after taking it for one month in connection with the use of prisms and electricity, the condition was rather worse. Rh. —1°, Ex. in accom. 6°. I gave him senega 1x and discontinued all other treatment. He was soon able to use his eyes comfortably, and in one month Rh. = ½°. He did not consult me again for seven months, when there was no hyperphoria, and Ex.—1°. Two months

later he had again Rh. $\frac{1}{2}°$. Senega 6x with faradism brought orthophoria in twelve days, and there has been no further relapse now for six months.

CASE XIV. Had facial paralysis cured by agaricus. Mixed astigmatism O. D., simple hyperopic astigmatism O. S. Slight asthenopic symptoms, not accurately recorded. Rh. — 4°. Senega 1x. In three days (without other treatment) Rh. — $2\frac{1}{2}°$. Continued senega with systematic exercise. In ten days Rh. $1\frac{1}{2}°$. Senega 1x. After three days more Rh. $2\frac{1}{2}°$. Continued senega and wear prism 2° up, left eye. Six months later (since commencing this paper) Rh. — $3\frac{1}{2}°$. Complains a good deal of asthenopic symptoms again.

CASE XV. Mixed astigmatism O. U. No asthenopia, but Rh. — $\frac{1}{2}°$, Ex. — 10°. Under atropia, Rh. 1°, Ex. 8°. Corrected refraction and prescribed senega 1x with no other treatment, and after wearing glasses and taking the remedy three weeks there was orthophoria far and near.

CASE XVI. Had chronic headache < by using eyes, dull pain over eyes, and burning in eyeballs. Hyperopic astigmatism O. D., H. Ah. O. S. Ex. 1°, in accom. 6°. Under atropia Lh. $\frac{1}{2}°$; no exophoria. ℞ ruta and wear vertical prisms for exercise. After eight days there was no improvement. Lh. as before; Ex. in accom. $1\frac{1}{2}°$. She was then given a prism of $\frac{1}{2}°$, with base up before the right eye, combined with suitable cylindrical lenses for constant use. Senega 6x was prescribed, and treatment with prisms and faradism was continued. In ten days there was orthophoria far and near (with her glasses). It is now three months since treatment was discontinued and she has had no return of headache or asthenopia.

CASE XVII. H. Ah. Frequent headache over eyes < by using them. Glasses relieved her very much, but she still had some headache. Es. $\frac{1}{2}°$, Ex. in accom. 2°. ℞ senega 1x for suspected latent hyperphoria. One week later she reported that she had been almost free from headache since the third dose. She continued free from headache four months, when the pain returned, and then examination showed Lh. $\frac{1}{2}°$, Ex. in accom. 10°. Senega 6x was given, and she has not been seen since.

ANALYSIS OF CASES.

An analysis of the foregoing cases gives us the following results: In Case I a Rh. of $\frac{1}{2}°$, Ex. of $1\frac{1}{2}°$ and of 3° in accom. was cured, and also the accompanying asthenopia (orthophoria being established) in ten days by senega 1x, systematic exercise, and faradism.

In Case II Rh. of 1° and the resultant symptoms were promptly cured by senega 6x without other treatment.

In Case III a Lh. of 5° was reduced to 2° and an Es.of 2° cured by the "mixed treatment." The improvement was more satisfactory while taking senega than at other times. Treatment was quite prolonged and the result quite satisfactory, but it was impossible to estimate to what extent the remedy contributed to the end attained.

In Case IV Rh. 3° and Es. 6° was cured by faradism, exercise, and senega, but here again it was difficult to judge of the individual value of the separate factors in the treatment.

In Cases V and VI senega was of no apparent service.

In Case VII senega was followed by prompt and permanent relief of asthenopia after the heterophoria had been in a large measure removed by other treatment.

In Case VIII Lh. 8° was reduced to 1° in five days by the remedy alone. Other remedies were necessary to relieve the asthenopia, but the diminution of Lh. was permanent.

In Case IX the effect of the remedy was directly the opposite of the preceding. The asthenopia was promptly relieved, but the hyperphoria (only ½°) was uninfluenced.

In Case X a Lh. of ½°, unaccompanied by asthenopia, disappeared under the exhibition of the remedy.

In Case XI we had a Rh. of ½° and an Ex. in accom. of 1½° cured. After three weeks of mixed treatment we had orthophoria far and near. The improvement was more marked while taking senega 1x, and it seems fair to give the credit in large measure to the drug.

In Case XII senega 1x cured the hyperphoria, but increased the headache. Senega 6x relieved the headache, but while taking it the Rh. returned. By alternation of the two potencies at intervals of some days a cure resulted. Prisms were used in addition, but no improvement resulted from the exercise, except when senega was taken at the same time.

In Case XIII the treatment extended over a long period, and was attended by frequent relapses. More satisfactory and permanent results were obtained while taking senega.

In Case XIV Rh. 4° was reduced to 2½° by senega 1x, and in two weeks it was still further reduced to 1½°. During this time prisms and faradism were employed four times. They were not used during the first three days.

In Case XV the remedy was used without other treatment. Rh. 1° and Ex. 10° cured, orthophoria far and near resulting in three weeks.

In Case XVI a cure was affected by the "mixed treatment," and again the influence of the remedy could not be accurately estimated.

In Case XVII the remedy was used alone. Very marked relief of subjective symptoms after third dose of senega 1x and no return of headache for four months.

RÉSUMÉ.

Cases II, VIII, IX, X, XV, and XVII were cured by the medicine alone, and hyperphoria of from ½° to 6° disappeared. In the other cases additional treatment was employed. In Cases V and VI the remedy seemed to be of little or no benefit.

In five cases treated with prisms and electricity the improvement was much more satisfactory while taking senega, so that it seemed fair to attribute a decidedly curative influence to the medicine. Thus in eleven out of seventeen cases we find positive benefit from senega, and in four more satisfactory results were obtained from the mixed treatment, but the value of the remedy could not be satisfactorily determined.

The following symptoms were either cured or greatly relieved by it, viz., "Pain in the eyes after reading." Pain behind the eyes < right and < by use." "Chronic headaches; severe pain (character not defined) after using eyes." Use of eyes causes pain in temples. "Pain and soreness in right eye and in head and occiput on right side." "Headache (not defined) after using eyes." "Frequent headaches over eyes < by using them."

I regret that the subjective sensations were not more frequently and accurately recorded, simply headache or asthenopia being sometimes noted. In one case senega 1x invariably increased the headache, although relieving the hyperphoria, while senega 6x relieved the headache, but did not correct the hyperphoria. Many other symptoms found in Allen and quoted by Norton were relieved by the mixed treatment, but I have mentioned only those where the relief could be directly attributed to the medicine alone.

Senega may be compared with onos., ruta, gels., argent. nit. and met. in the class of cases under discussion, but the limits of this paper forbid more than a mention of them.

ULCER OF THE CORNEA CURED BY CHIN. MUR.

ALTON G. WARNER, M. D.,

BROOKLYN.

Mrs. A—age 35 called upon me a few weeks ago, suffering as she said from "pink eye." The right eye had been inflamed and painful for a month, and for a week past the pain had been very distressing. She had been treated by an old school physician who discovered the ulceration, but told her that he would cure the "pink eye" first and then attend to the ulcer. As she only grew worse she concluded that something else must be done and came to me. Upon examination of the eye I found intense conjunctival and sub-conjunctival injection and at the inner and lower quadrant of the cornea a sloughing ulcer, about two lines in diameter surrounded by a zone of haziness. The iris was sluggish and the ciliary region sensitive to touch. Upon questioning the patient, I learned that the pain and photophobia was much greater every second day. On the alternate day she was fairly comfortable. Her general condition was not good as she had been overtaxed in long care of a sick relative.

Upon the symptoms of marked periodicity, I prescribed Chin muriate 1st cent. trit. every 2 hours; and told her to report in two days. At the end of that time she was very much improved. Had suffered no pain. The congestion was much less, and the ulcer cleaner. The remedy was continued every three hours. At the next visit the congestion had nearly disappeared and the ulcer filled in; and in a week from first seeing the eye it was well except for a slight macula at the seat of the ulcer. This case is reported only to show the homœopathicity of the remedy.

DISLOCATION OF THE LENS, AND SUBSEQUENT CATARACT BY A SHOT FROM AN AIR GUN.

ALTON G. WARNER, M. D.,

BROOKLYN.

The peculiarity of this case is the fact that the lens was not touched or the eyeball perforated, but the luxation occurred as the result of shock. The patient, a boy of fourteen, I saw at the request of Dr. Chapin. Two days before an air gun in the hands of a younger brother had accidentally been discharged and the patient felt the shot strike his eye. Upon examination I found the eyeball much inflamed and rather sensitive to touch, the pupil dilated, and iris tremulous, showing that it was not supported by the lens, which was dislocated directly backward. For some time I could not find any trace of the shot, but rolling the eyeball as far downward as possible and drawing the upper lid well up, I discovered the shot beneath the conjunctiva, but without the sclera. The lid was not wounded at all. A slight incision in the conjunctiva released the shot and it popped out. A dressing of calendula with aconite internally soon restored the eye to normal condition, except the lens. This soon became opaque, as dislocated lenses are prone to do. A portion of the lens has since become absorbed, so that there is some peripheral vision. I have no doubt but that the whole lens could be absorbed by needling and clear vision obtained could the family be induced to give consent to the operation.

A CASE OF NUCLEAR IRIDOPLEGIA.

CHAS. C. BOYLE, M. D.,

NEW YORK.

Mrs. C., aged forty-eight, consulted me in May, 1889, on account of headaches from which she suffered, thinking that her eyes might be the cause of them, as she often had diplopia.

On examination found R. V. $= \frac{20}{40}$, $+.75\,D^{s}. \bigcirc +.25\,D^{c}.$ ax. $90° = \frac{20}{40}$; L. V. $= \frac{20}{100} - 1\,D^{s}. \bigcirc -.50\,D^{c}.$ ax. $165° = {}^{20}$. Phorometer showed exophoria 5° for distance and 8° for near vision. Left hyper-

phoria 1°. Ophthalmoscopic examination showed a normal fundus, except that in the left eye there was a small posterior staphyloma. Pupils normal.

Besides prescribing glasses, I commenced treatment by trying to strengthen the muscles by exercising with prisms. At first the internal recti could not overcome more than a 10° prism, and instead of improving they gradually grew weaker, until finally they could not overcome more than a prism of 2°. At this stage, although not a believer in the theory that tenotomy of the eye muscles will cure all the ills that flesh is heir to, I advised tenotomy of the external recti, which was consented to and performed, and was followed by greater relief, although not entire cessation from headaches, than she had had for years. From the time I first saw patient, vision gradually grew less; in May, 1889, it was $\frac{2}{40}$ with glasses; in September, 1889, R. V. $= \frac{2}{40}$, L. V. $= \frac{2}{100}$; in May, 1890, V. $= \frac{2}{100}$; in May, 1891, V. $= \frac{2}{200}$; in June, 1891, V. $= \frac{1}{200}$, and since then it varies from $\frac{1}{200}$ to $\frac{6}{200}$ O. U. About one year ago I noticed that the pupils had become dilated to about their full extent; tension normal. Pupils would not contract from the action of light, showing a loss of the reflex action; the power of accommodation was not affected, but pupils did not contract when patient was using accommodation. A solution of sulphate of eserine 1–200 caused no contraction. At times while under treatment there would be a very slight contraction of the pupil, but it did not remain long, and at the present time they remain dilated to about their full extent. For the last year the patient has been troubled for a good part of the time with a passive congestion of the ocular conjunctiva, unaccompanied by any catarrhal discharge from the eyes, showing it was not a catarrhal condition but probably due to the same causes that were affecting the eye otherwise.

Have examined the eye repeatedly for commencing atrophy of the optic nerve, but cannot discover any; in fact, the disks look the same as when I first saw the patient. Field of vision very much contracted now, but there is no loss of color vision, and the patient apparently suffers very little inconvenience from her loss of vision; goes around as she always did, and can read ordinary print with her near glasses that I prescribed when I first saw her, with very little inconvenience, and this I consider a remarkable feature of the case, considering the loss of vision for distance. There is hardly any doubt but that atrophy of the optic nerve will make its appearance at some time in the future, but from the history of the case you would have expected it long ago.

Her trouble is probably due to some lesion in the brain, undoubtedly in the region of the nucleus of the third nerve, because it is in this region that the nerves that control the action of the iris originate. It has been found that the nucleus of the third nerve contains a series of centers corresponding to the several functions of the nerve; the most anterior related to accommodation, the next to the reflex action of the iris, while the remainder of the nucleus controls most of the recti muscles. The path through which the reflex action of the iris is produced is the optic nerves, both optic tracts, corpora quadrigemina, and the anterior part of the nucleus of the third nerve behind the center of accommodation. In this case the dilatation of the pupil and loss of reflex action of the iris are probably due to some trouble in the brain at the seat of the anterior part of the nucleus of the third nerve, which controls this action. The partial loss of vision would also have something to do with this dilatation of the iris, and loss of reflex action.

Notwithstanding the loss of vision, this patient's eyes are sensitive to light, so that she wears smoked glasses in the street, and ophthalmoscopic examination is always more or less painful. In the treatment of this patient I have given different remedies that seemed to be indicated, besides using electricity, both galvanic and faradic currents, but nothing seemed to be of any use. Have had the patient examined by Dr. O'Connor, who also gave his opinion that the trouble was due to some central lesion.

SOUND AS A FACTOR IN THE TREATMENT OF DISEASE OF THE SOUND-CONDUCTING APPARATUS.

HENRY C. HOUGHTON, M. D.,

NEW YORK.

Sound is an essential force in nature, or, if you please, one of the manifestations of the one great force which is manifest as heat, light, electricity, magnetism, gravitation, etc. We will leave it to the philosophers to tell us what force is, but the theories advanced to explain the phenomena of "sound," as a force, are of interest to us. The former theory that sound, as a sensation, was the result of air

waves, which put in motion the drum-head and related bones, thereby communicating waves or oscillations to the fluids in the labyrinth, and from the terminal filaments of the auditory nerve floating in those fluids, the impulse was translated to brain centres, giving the sensation of "sound." A more recent hypothesis advances the idea that sound is an essential force, like light, heat, magnetism and electricity in its various forms, and there are some phenomena which are explained by such a hypothesis.

Looking at sound as a cause, the effects produced are good or bad according to the circumstances which exist when the exciting cause is sufficient to produce an observable effect. Sound acting upon a normal conducting apparatus, usually produces only good effects, so that the subject is not aware of any defect or deviation from perfect function. Sound may be the cause of discomfort, then of functional disturbance, and eventually of abnormal conditions which become permanent. A normal ear, under ordinary conditions, will give perfect function through the entire period of life, and should no more fail than does the eye. Old-age should have perfect hearing as well as perfect sight.

The uncomfortable subjective symptoms which arise from the effect of sound, are due to such causes as are active in the well-recognized boiler-maker's deafness, in which the cause is excessive action of a normal apparatus; subjective sounds are also due to the action of causes that are not excessive, acting upon an abnormal apparatus, such as those changed by catarrh or suppurative disease. The rationale of deafness and subjective sounds, is very simple; the conducting apparatus lying between the canal and the auditory nerve has been subjected to various changes, usually characterized as "hardening," the result of catarrhal inflammation, suppurative inflammation, rheumatism or gout. This rigidity prevents the conduction of sound or causes an inward pressure upon the fluids of the labyrinth, mainly at the oval window, thereby changing the normal tension of the labyrinthine fluids, and theoretically modifying the tuning of the apparatus to the circulation of the part; at least, this is the best hypothesis which aurists have yet offered for the phenomena of subjective sounds. The necessity is a clear one, and the indications for treatment equally clear, namely: to overcome the rigidity caused by disease, and restore the mobility of the parts. The history of attempts to meet this necessity is a long one, and full of interesting mechanical devices offered by various aurists, in England, on the Continent, and in this country. Efforts to open the Eustachian tube are among the earliest; the Eustachian catheter, Politzer's method of inflation, Valsalva's experiment,

are all well known, and each of them effective. The devices intended to move the drum-head and ossicula by direct action upon the surface of the drum-head, either in conjunction with inflation, or independent of it, are included in another group. The use of a suction apparatus, such as a stomach-pump, causing excursions to and from the drum-head, Lucæ's stempel, Siegel's otoscope, are suggestive instruments. These all offered some hope of improvement, but all these instruments are crude and coarse in their application.

The first advance over the above cruder methods, that came to my attention, was that of Mr. J. Maloney, of Washington, D. C., called "otacoustic treatment," which was presented to the American Otological Society some years since, but it failed to make a wide impression upon the profession, possibly because this gentleman protected his interests by a patent covering the device. My attention was called to it again later on, by an article by Dr. King, of Washington, a practitioner of our own school. Since then, Prof. Henry F. Garey, M. D., of Baltimore, has utilized the phonograph for the same purpose that Moloney used his conversation tube, and thereby has given the whole subject of aural massage a very great impetus. The sound pulses as produced by the diaphragm of the phonograph, conveyed by the stethoscopic tube to the canal and drum-head, produce an appreciable message, which is made evident by congestion of the drum-head, increased mobility of the same, subjective symptoms in the way of increased heat, and modification of the subjective tones. This new departure of Prof. Garey's has produced an interested experimentation on the part of a good many observers, and several attemps have been made to produce the same effects as are produced by the phonograph, experimenters utilizing musical instruments. Prof. Garey's "vibrometer," so-called, consists of an instrument similar to a banjo, with strings, frets, and a vibrating wheel, similar to a hurdy-gurdy attachment; this acting upon the strings over a resonanting chamber, the sound impulses are conveyed to the canal and drum-head by stethoscopic tubes, similar to those used on the phonograph. I have been using since last June a reed instrument for the same purpose, and find that the effects are much the same. Dr. Wilson, of Meriden, Conn., writes me that he has used a guitar and later a reed organ.

In closing this article, it may be well to give a brief summary of the effects produced: On the canal and drum-head, heat, itching, redness. The heat should be considered an indication that the sitting has been sufficiently prolonged. The itching is more or less pronounced,

transient in some cases and long-continued in other cases, causing the patient to rub at the ears, and complain of the annoyance for hours. The redness is usually quite marked at the inner third of the canal, at the periphery of the drum-head over Shrapnell's membrane, and along the manubrium plexus. The head generally becomes more or less sore, soreness of the scalp, of the muscles attaching to the aponeurosis of the temporal bone, in a number of cases extending to the occiput, and in one to the neck and shoulders. Increased mucous secretion has been observed in a number of cases,—one very marked. Upon the acoustic nerve, we note relief of subjective sounds, without increase of hearing for the watch or the voice. Relief of subjective sounds, with increase of hearing for watch and voice. Increase of the audition, without increase of subjective sounds. Peculiar response of the auditory nerve is noticeable. As a rule, we notice failure for the high tones is more marked than for the low tones. In some cases, the perception of the higher tones is not well defined. There is a perception, but it is not clear and sharp, two or three consecutive notes sounding very much alike. In one case, the high tones were not clearly defined until we had passed over two octaves, or an octave and a half, two or three times, dwelling on each vibration. Then the perception came out clear.

The action of such remedies as causticum, chenopodium, in my judgment has been very much increased by aural massage.

My conviction, that we have in this new method a very valuable adjuvant to previous methods of treatment, has been deepened and strengthened by further study and experiment, and it is gratifying to know that a large number of our school are very much engaged in study and experiment along this line.

DISCUSSION.

E. E. KEELER: The subject of Aural Massage is one in which every physician devoting his attention to diseases of the ear feels a peculiar interest at this time. In the treatment of this class of diseases we were constantly meeting cases where we could not conscientiously have offered a grain of comfort, unless it were the half-hearted suggestion that we might, by following a proposed course of mechanical and therapeutic treatment stop the onward progress of the disease and prevent further diminution of hearing. Therefore anything proposed whereby we may be able, by the introduction of new methods to add

to our success in the treatment of this class of cases is joyfully received. I have been personally so greatly interested in the method adopted by Dr. H.F. Garey, of Baltimore, to produce systematic massage of the middle ear that I traveled from my home in Syracuse to Baltimore for the express purpose of getting in touch with the inventor and receiving from first hands the theory upon which the instrument, called by him the vibrometer, is based and the conclusions to which he has arrived.

Every physician introducing a new method of practice becomes enthusiastic concerning it, yet Dr. Garey does not claim that the instrument will cure each and every case of deafness, entering his office, but he does claim that it offers 50 per cent. more chances of curing deafness resulting from long standing catarrh of the middle ear than any other known method of treatment. I am proud that we have in our ranks the inventor of this instrument, and confidently believe that by its use together with the administration of the indicated remedy we shall achieve good results.

This instrument makes it possible for a certain number of vibrations per second to be transmitted to the ears. These vibrations are produced by the striking of projections upon a rapidly revolving wheel against metalic strings of various lengths and degrees of tension. This wheel is driven at rapid speed by an electric motor. The use of the instrument is advised for a period of from 5 minutes to 15 minutes.

REPORT

OF THE

BUREAU OF SURGERY.

"Suturing the Tendo-Achillis," - - - DEWITT G. WILCOX.
"Fracture of the Base of the Skull, with Delayed Symptoms," - - - H. P. SAGE AND H. B. MINTON.
"Three Cases of Appendicitis (?)— No Appendix" - - - - - SIDNEY F. WILCOX.
"The Removal of Facial Blemishes by Electricity," - - - - - WILLIAM HARVEY KING.
"Promiscuous Cases in Gynæcology and Surgery," - - - - - - HARRISON WILLIS.

SUTURING THE TENDO-ACHILLIS.

DEWITT G. WILCOX, M. D.,

BUFFALO.

To unite successfully a ruptured "tendo achillis" by an open incision exposing both its ends has not been accomplished so frequently that its performance will not bear rementioning. In looking over the surgical literature on the subject it is rather interesting to find how frequently the various authors speak of the feasibility of such a procedure in case the tendon fails to unite of itself, and also to notice the remarkable paucity of cases mentioned to demonstrate its practicability.

As is my usual custom, when I want a few terse, practical words on a surgical subject I refer to the work of our distinguished member, Prof. Helmuth. While he mentions the performance of the operation, no cases are cited.

Ashurst speaks of the propriety, and in extreme cases necessity, of exposing the ruptured tendon and uniting by suture. Gross says, "In rare instances, when the ruptured tendon fails to unite after proper position and rest, it is best to open up the sheath, square the ends and suture, preferably with metallic sutures." He concludes by saying

that a number of cases are recorded where complete success followed the operation. Holmes says that the mode of bringing the ends of the divided tendon together by means of sutures can scarcely be recommended since they produce too much irritation; but Packard, who has made a revision of Holmes's work, adds, "Few surgeons at the present day would agree with the author that sutures can scarcely be recommended, as in many recorded cases complete recovery has followed their employment." In the Annual of '92, Sayre speaks of Poncet's suggestion, that in such ruptures where the ends cannot be brought together without producing equinus, the os calcis be sawed through perpendicularly so as to allow the posterior fragment, with the tendo "achillis" attached, to be slipped up and nailed on a higher plane: of this I shall speak hereafter.

From the fact, therefore, that so many authors have mentioned the feasibility of such an operation, without citing any cases to verify their statements, I have considered it of sufficient importance to venture this report. It is something of a unique case in these respects, —a long time elapsed from the injury until the operation, its failure; the second operation and its result.

Mr. John B. is a middle aged man, rather heavy set and weighing about 180 pounds. On the sixth day of June, 1891 he was running to catch a train when he slipped on a rolling stone, (one of the unmossed variety) throwing his foot violently backward. He was unable to walk further and was carried home. His attending physician regarded it only as a severe strain, notwithstanding the patient told him of the distinct sensation of something giving way in his heel. In a short time he was allowed to go around with the use of a crutch, and thinking that he would soon be able-bodied, condescendingly settled with his accident insurance company; but the acceptance of an indemnity does not always insure restoration to health.

When I saw the patient in September of the same year, four months after the accident, he was using a cane and a crutch and bearing very little weight on his foot. He was scarcely able to raise the heel from the floor, even when sitting, and increased work placed upon the lateral ligaments had caused them to weaken perceptibly. It was not difficult to distinguish a depression of two inches directly over the tendon, and I was at once convinced that the tendon was completely ruptured and that there was very little chance of its recovery by rest and posture. I found upon opening the sheath of the tendon the two ends, however, instead of being blunt or irregular were pointed and tapered down to an attenuated cord about the size of a goose quill; this little connection

was vainly endeavoring to perform duty for the great tendon of achilles. To cut off these two pointed ends and square them ready for union seemed to me a greater sacrifice of tissue than I was justified in making, so I united them more in the manner of splicing by using heavy catgut ligatures. The foot was well extended and placed in a plaster cast. All went well, the incision healed quickly and the tendon seemed firm. In the course of three months he began using the foot and could utilize it to quite an extent in springing the body forward. At the end of four months, however, it began to weaken gradually until he was nearly, if not fully, as helpless as before the operation.

Being obliged to come to New York last spring, he took the opportunity to consult some of your shining lights and, of course, came home enlightened but poorer. Profs. Helmuth, Bryant and Markoe all advised him to try the operation again. They explained to him frankly the difficulty of inducing tendons to unite and that failure to do so does not necessarily mean a faulty operation. He came to me last March and requested that I should repeat the operation. I felt that the mistake in the first operation had been in not removing enough tissue to give the large stumps for union. I therefore determined to do so the second time even at the expense of producing an extreme equinus.

Upon opening the sheath I found very much the same condition as existed the first time. I cut off fully half an inch from each extremity, which, with the shortening that had already taken place and the contraction of the calf muscles, left an interval of more than three inches, and fully one inch when the foot was forcibly extended. By seizing the upper fragment with a strong pair of tenaculum forceps and forcibly dragging down the muscles and by drawing upward in a similar manner the lower fragments the ends were brought within half an inch of each other. Three heavy chromicised catgut sutures were inserted and the fragment held together as firmly as the distance between their ends would allow. The sheath was then sewed around it, the integument coapted, an anterior splint applied, and the patient put in bed. No change of dressing was made for four days; at the end of eight days there was a little discharge; while washing this out the ligatures were withdrawn unchanged.

It was four weeks before he left the hospital, two months later he discarded the splint; then began a careful and intelligent use of the tendon. At first he wore a high-heeled shoe, and by removing a lap every week was in time able to stand on the foot. Seven months after the second operation he wrote me the following letter, "I am happy

to be able to say that I am making satisfactory progress toward recovery. I can now exhibit a very fair sample of walking. I abandoned my cane about two months ago, and, although I still indulge in a slight limp, yet I feel a constant improvement. The tendon is, I am convinced, quite strong and the calf muscles show considerable development; it measures now 14⅝ inches, 1⅛ inches below the normal size, showing a gain of 1⅞ inches in three and a half months, which to me is decidedly gratifying, and I believe your interest in it is second only to mine. In walking I raise my heel fairly well and get considerable spring from the action. The shortening of the tendon will not interfere with my walking nor any usual action. I feel some inconvenience from the joint but that is improving and—well, I can walk as fast as you can, 'tho perhaps not so gracefully.

Yours very truly,

JOHN H. BLACK.

To my mind the case has made the following points prominent:

1. The ends need not be in contact to secure union.

2. That chromic acid catgut is preferable to others, as it is non-irritating and will not cut through when there is much strain; it does not melt down, and it also acts as a carrier of plasma when the ends are some distance apart.

3. That even if an extreme degree of equinus may be produced by a short tendon it may be overcome simply by stretching.

Before closing let me quote briefly from that most classical work, Paget's Pathology, on the repair of tendons. "At the instant of division the ends of the tendon separate to the distance of nearly an inch, the upper portion of the tendon being drawn up the leg by the action of the gastrocnemius and soleus muscles. The retraction is comparatively much greater than is usual in operations on the human achilles tendon; for where these are done, the muscles are seldom capable of strong or extensive contraction. It is in all cases to be remembered that the separation is effected entirely by the withdrawal of the upper portion of the tendon; the lower, being not connected with muscle, remains with its end opposite the wound. To this we may ascribe the general fact that the reparative process is more active, and the inflammatory process is less so, at the upper than at the lower portion of the tendon; for the latter lies in the very center of the chief inflammatory action; while the former is removed from it, being drawn away at once from the seat of injury, and from even the slightest exposure to the air. I have already said that very little blood is effused in the subcutaneous operations. Commonly only a few blotches of extrav-

asation appear in and near the space from which the upper part of the tendon is retracted. The first apparent consequence of the division of the tendon is the effusion of a fluid or a semifluid substance which, like the product of common inflammation, quickly organizes itself into the well known forms of lymph or exudation cells. These, speedily becoming more distinctly nucleated and elongated, undergo the changes I mentioned in describing the development of cells in granulations. The exuded lymph makes the tissues at and near the wound succulent and yellow, like parts infiltrated in anasarca. The blood vessels near the divided tendon enlarge, as in an inflamed part, and appear filled with blood. The exudation, together with the enlargement of the vessels, swells the parts, so that the skin is scarcely at all depressed between the separated ends of the tendon."

The objection I would make to Poncet's method of sawing off a portion of the os calcis to which the tendon is attached, and slipping it up in order that the ends of the ruptured tendon may be more nearly approximated, is, that it is unnecessary in all ordinary cases. There may be a condition, where the tendon is torn off or destroyed by a missile, that would render advisable this procedure but from an ordinary rupture there could scarcely be found a case where the ends were further apart or the equinus more extreme than in the one just related, yet they united and a perfect tendon remains with normal elasticity.

FRACTURE OF THE BASE OF THE SKULL WITH DELAYED SYMPTOMS.

Case History by HENRY P. SAGE, M. D., House Surgeon Brooklyn Homœopathic Hospital.

Autopsy by HENRY B. MINTON, M. D.

BROOKLYN.

The following history may be of interest as showing that a patient may have an extensive fracture of the skull and yet live a week or more without giving any evidence of it.

On April 9th, 1892, Mr. Geo. S———, aged forty-five, was knocked down by a runaway team and our ambulance responding to the call Dr. Bierbauer brought the man to the Brooklyn Homœopathic Hospi-

tal. The only injuries apparent were as follows. Fracture of the humerus with separation of the clavicle from the sternum. Fracture of the nasal bones; severe contusion of the thorax; scalp wound over the occiput (not severe); contusions of the face and hands. The ambulance surgeon reported that the patient was perfectly conscious when first seen. Probing the scalp wound indicated no signs of fracture. The slight hæmorrhage from one nostril was attributed to the contusion of the nose. There was no bleeding from the nose and the pupils were normal. The patient had a slight rise of temperature on the first and second day, as is not unusual in cases of simple fracture. He appeared a little dazed and complained of his back and side but not of his head. During the next four days he was bright and talkative, and his temperature and pulse were normal. On the sixth day he was feeling so much better that he advised his wife to go out of town on a visit, which she did. That evening his temperature rose to 101, but owing to pain in the thoracic region inflammation was thought to be there. On the morning of the seventh day his temperature was 101.6° and at four P. M. 104°. Still he was perfectly conscious, read the newspaper, and gave no indications of cerebral trouble. When questioned he said he felt "all right." But on the next morning he became drowsy and by five P. M. had marked systoms of compression of the brain. A few hours later trephining was performed by Dr. Harrison Willis, but no marked relief was obtained. The patient sank into a deep coma and died during the night.

The autopsy was performed on the eighteenth of April. The injuries enumerated above were found present. The contents of the thoracic and abdominal cavities were normal, and the interest of the case centers in the lesions found in the head.

The skull-cap having been removed the left hemisphere of the cerebrum was seen covered by a thick layer of pus which had accumulated beneath the dura mater. On the inner surface of the vertical portion of the frontal bone to the left of the median line was a blood clot about as big as a half dollar. The inferior surface of the left frontal lobe was soft and degenerated and the seat of a collection of pus. It presented an appearance as though it had been fractured for a distance of about two inches as though a pus formation had taken place in the fissure. In the base of the skull a fracture commenced on the frontal bone about two inches above the orbital plate slightly to the left of the median line and extended down the vertical plate of the frontal, across the cribriform plate of the ethmoid, through both roots of the lesser wing of the sphenoid, thus involving the optic foramen,

across the body of the sphenoid just internal to the cavernous sinus, and turning to the left entered the foramen lacerum· medius and the carotid canal, there it was deflected backward across the tip of the petrous portion of the temporal bone to the anterior condyloid foramen thence beside the margin of the foramen magnum and along the occipital bone parallel with the median line to a point a little below the lambdoidal suture. This point corresponded pretty closely with the left hand extremity of the scalp wound, but the fracture was here simply a minute crack and could not be detected externally. Several small fissures extended from the main break especially over the left orbital plate of the frontal bone.

The main line of fracture roughly measured was twelve and a quarter inches in length and split the skull more than half in two. The fracture is described from the upper surface of the base of the cranium but what its extent on the inferior surface or in the walls of the orbital and nasal cavities would have been it was impossible to examine.

It is probable that the blow producing this fracture was received over the root of the nose. This patient was in the hospital under constant observation six days without any symptoms save those dependant upon the known injuries, yet after death he was found to have sustained a fracture of the base of the skull at least a foot in length which had given no evidence of its existence until the seventh or eighth day after the receipt of the injury.

THREE CASES OF APPENDICITIS(?)—NO APPENDIX.

SIDNEY F. WILCOX, M. D.,
NEW YORK.

My object in writing this paper is not to throw discredit on the diagnosis made in the cases referred to but to show how the diagnosis made of an abdominal disease may fail of verification when the abdomen is opened.

One can usually diagnose an abdominal abscess but not always, for many abscesses in the abdominal cavity have been diagnosed as something else and vice versa.

Whether the three cases which I am about to relate had any trouble with the appendix or not, I am unable to state, but they all had the important symptoms pointing to appendicitis—in its chronic form—

1st. Frequently recurring attacks of violent pain in the right iliac region accompanied by tumefaction, sensitiveness over "McBurney's point," obstinate constipation, rigidity of the abdominal muscles and more or less fever. In all these cases rectal examination revealed nothing.

CASE I. Mrs. N———, a young married lady, resident of Brooklyn, where Dr. W. B. Winchell is her family physician. The doctor has kindly given me the previous history of the case, which in brief is as follows: When he first saw her November 6, 1891, her life was despaired of. She had been ill for two weeks with so-called peritonitis under allopathic treatment, but could not take the medicines prescribed as for ten days the stomach had rejected everything and she had been fed per rectum. The bowels were obstinately constipated, bowels and stomach somewhat distended, and gas was belched constantly. No fever, little tenderness at time of his call. All opiates were stopped, indicated remedies given, and in a few days bowels were moving spontaneously and food was taken by stomach. For the first few days the movements consisted of albuminous looking mucus.

The second attack occurred March 3rd, 1892. She vomited large qantities of undigested food, abdomen enormously distended and agony intense. Pain located at the umbilicus. There was much gurgling in ileo-cæcal region but tenderness less marked than at umbilicus and even higher. After hours of persistent effort the bowels were relieved and large quantities of flatus passed. There was little rise of temperature and no rigors. No tumor could be detected, apparent recovery followed although enemata had to be resorted to to move the bowels.

On April 6th she had a similar attack but less severe.

Dr. Willis in consultation could detect no tumor. Still some gurgling in ileo-cæcal region temperature not high and no rational signs of pus. Dr. Willis thought an operation would be required later but not urgently demanded at the time. Rapid recovery but bowels very constipated fæces, round small and hard as though they had passed through a small aperture. No pus in any of the movements.

On May 1st she had a 4th attack but less severe. Same conditions present as before. Was quickly relieved by opium 30th. Only one visit required. On June 1st she went to the seashore.

In July while at the seashore she had another attack and was under the care of Dr. J. F. Ackerman, of Asbury Park, N. J., and was seen by Dr. J. M. Schley in consultation. As nearly as I can learn *this* attack was similar to the preceding except more severe. With this

attack she had chills, fever and other signs of suppuration. On examination Dr. Schley found what he believed to be a perityphlitic abscess and advised operation.

I saw her first on the 21st of July, with Drs. Schley, Winchell, Ackerman and Adams. The patient was excessively nervous and a physical examination was exceedingly unsatisfactory. Even after she was under ether only a very indistinctly defined lump could be found on palpation as the abdominal muscles were extremely tense. There was resonance on percussion over the whole abdomen. The large fluctuating tumor, which Dr. Schley had felt three days before had almost disappeared. After a careful consideration of the matter it was decided from the history of the case that it was justifiable and advisable to make an exploratory laparotomy to determine definitely if a diseased appendix or if not that, what was the cause of the trouble.

An incision was made running downward and inward, nearly parallel with Poupart's ligament, this was only through the skin and fasciæ, as when these were retracted I could distinctly feel a hard mass under the remainder of the abdominal wall. The line was then changed, that the incision ran more directly over the lump. The peritoneum being opened disclosed a mass of intestines closely adherent and firmly bound down in the pelvis. There was a great deal of inflammatory deposit so that the topography of the parts was nearly lost. With great care I broke up many of the adhesions, but could not loosen the adhesion to the pelvis without great danger of rupturing the intestines. Although I searched with the greatest care I could find no pus or fluctuating sac, and we came to the conclusion that it must have ruptured into the intestines and passed off in the copious stool which she had had. I could not find the appendix. The wound has closed without drainage except a tube under the superficial layers first opened, and the usual dressings applied.

The patient recovered slowly, she has had no trouble since, is free from pain, but is very thin and weak and lives on a restricted diet.

CASE II. Being called out of town in another direction the night of the operation of case I., I did not reach my office until about half-past nine the next day, July 22nd, when I found a telegram awaiting me from Dr. H. E. Rice, of Springfield, Mass., requesting me to come immediately to operate for appendicitis.

The details of the history were almost identical with those of case I, so nearly so that it is hardly necessary to go into them. The patient was a gentleman whose business required him to travel a great deal, but the attacks had become so frequent that he dared not leave home

for fear of one coming on during his absence. He had been under old school treatment until within a day or so and had consulted Dr. W. T. Bull of this city, who had diagnosed appendicitis and advised operation, but before he had made up his mind to have it done Dr. Bull had sailed for Europe and he came into my hands. On the day before the operation Dr. Rice had distinctly mapped out a tumor in the right iliac region, but after the large movement of the bowels on the morning of the operation I could not be sure that I felt a tumor and the whole abdomen was resonant on percussion. Rectal and bimanual examination negative—patient was extremely sensitive over the region of "McBurney's point" and abdomnal muscles very rigid.

Taking into consideration certain difficulties which had arisen in the operation the day before, I made an exploratory incision in the median line. This was a mistake for I found that the extreme tenseness of the recti muscles prevented my working with any degree of facility. I should have made the incision outside and perhaps parallel to the rectus. Although, as in the previous case, I was able to feel a lump I could not handle it and was reluctantly obliged to make another incision parallel with Poupart's ligament. The intestines were closely matted together but the adhesions not being very strong I was able to break them up without effort while feeling with my finger for a pus sac. I could not find any sac, but suddenly without any sensation of anything having ruptured pus appeared in the wound. About an ounce was removed and that was all. No pus cavity could be found nor could an appendix, although we searched carefully. The abdominal cavity was carefully irrigated with hot water and then wiped out. A glass drainage tube placed leading down into the iliac-fossa and iodoform gauze packed between the tube and the intestines and the wounds closed. The patient reacted slowly but fairly well at first but died about six hours afterwards from shock.

How much the hot water irrigation is responsible for shock I am unable to decide, but I am growing decidedly suspicious of that means of cleansing the abdomen. It is necessary at times perhaps, but in every case in which I have tried it I have had severe depression follow, although this case was the first resulting in death, which, however, after all may have been due to the severity of the operation.

CASE III. On August 3rd I operated in Jersey City for Dr. E. W. Pyle on a gentleman whom I had seen a few days before in consultation. The history given briefly by Dr. Pyle is as follows: "While visiting an insane relative some two years ago he (the patient) was

kicked violently in the stomach or rather in the right iliac region almost knocking him to the floor. It was done with the heel in a forward thrust. Two months afterwards he was seized with a violent pain in the *left* leg between the knee and the body—radiating pains on the inside of the leg—this was thought to be due to renal calculus but later developments revealed the perityphlitic condition. Some months later he had a second attack without the *left* leg complication. He was confined to the bed for a few days and was relieved by poultices and opium. A few months later a third attack, confining him to the house for one or two weeks was relieved by morphia and antikamnia. A fourth had the same history. The fifth and last attack commenced with abdominal pain in the *left* side and gradually centered in pain and tenderness in the right side. With all these attacks there has been fever. He had from time to time some wandering pain in the bladder, which led another doctor, under whose care he was for a time, to the belief that the neck of the bladder was the seat of the trouble, (and for which he was treated with sounds, etc). He has been a temperate and industrious man with good family history. The reflex symptoms in the left leg, left abdominal region and the bladder make the subject one of interest."

When I first saw him in consultation the patient was in bed. He was inclined to be stout and with considerable fat over the abdomen, which made the examination more difficult. The pain was in the right iliac region. He was excessively sensitive to pressure, especially at a point about an inch nearer the ant. sup. spin. process of the ilium than McBurney's point. The abdominal muscles on the right side exceedingly tense. Dullness on percussion was not easy to elicit on the first examination but when the patient was under ether before the operation a strip about an inch or so wide along the ilium could be made out. Rectal examination yielded negative results. He had every day fever and sweats, the temperature ranging from 101 to 103. Between the time of the first examination and the operation the symptoms increased markedly in severity so that operation could not be delayed.

The incision was made over the tumefaction in line with and about an inch from Poupart's ligament. The first incision revealed the œdematous appearance of the underlying tissues which indicated the presence of pus underneath. A good free opening was made and a quart of fetid pus discharged. The cavity was found to be entirely extra-peritoneal and ran backward and upward behind the liver as a flexible tube could be run a foot in that direction. After thoroughly

washing out the cavity the wound was loosely closed, leaving a large drainage tube *in situ*. For four weeks after the operation the patient had no rise of temperature. Then he had some trouble probably due to imperfect drainage, but that difficulty was obviated and now he is doing well. Of course the peritoneal cavity was not opened. The origin of the disease is not certain whether typhlitic, perityphlitic or appendicitic. Doubtless the origin of the abcess was inside the peritoneum but adhesion had formed and the pus had burrowed posteriorly along external to the peritoneal cavity.

The tumor apparent on examination was so disproportionately small as compared with the great amount of pus that in the general appear ance this case closely resembled cases I and II.

The history of these cases shows that while in all of them the presence of abcess could be easily diagnosed, its origin and situation even are masked by the lack of dullness on percussion and the great difficulty of making out any tumor by palpation due to the extreme sensitiveness to pressure and the rigidity of the abdominal muscles. The resonance on percussion in cases I and II is accounted for by the fact that the tumor which was found on opening the abdomen consisted in a mass of inflated intestines bound together by adhesions.

The status of the operation for appendicitis is not yet settled. Surgeons are divided in opinion on the subject as regards the advisability of operating in early cases. Even so eminent a man as Treves opposing it, but in cases such as I have related where the presence of pus is so apparent there can be no question as to its advisability.

DISCUSSION.

D. G. WILCOX: I had a case about two weeks ago, which I presume would have resembled Dr. Wilcox's first case had it been of longer standing. A boy about fourteen had been sick a week when I saw him. I made an incision and as soon as I reached the peritoneal cavity there was an escape of pus. There was the same matting of the intestines with the abdominal peritoneum which made it somewhat difficult to find the seat of the disease. By burrowing deeper and separating the parts I found what was the remains of the appendix, about a quarter of an inch, very much broken down, but enough to show that it was the appendix. I have no doubt the trouble began in the appendix itself. As it was I was able to remove what remained,

cutting out as much of the diseased tissue as became necessary and suturing it carefully; it is now about three weeks since the operation and he has made a very satisfactory recovery. I make my incision right over the tumor, for the appendix may vary in its location. Make an early incision. If you find there is enough of inflammation to result in pus, then you will have to operate or lose the patient.

JOHN L. MOFFAT: I would like to ask if, generally speaking, there is less danger of relapses in cases of operation. As I understand it there will be adhesions whether the pus be evacuated surgically or not. I have in mind one case where the attending surgeons hesitated to operate, and finally did not cut; for about two years afterward the patient was subject to more or less severe attacks of the same pain, but now regards himself as cured. It has always been a question with me whether there has not possibly been a casefication of pus, which has been responsible for some of his relapses and which might have been obviated by an operation.

H. F. BIGGAR: Much of the discussion about early operation for appendicitis would be cleared up by substituting the word timely for early; the question would then be what constitutes a timely operation. We should not hesitate to operate at once if the patient is comatose with a history of severe pain. Other important symptoms are tympanitis and, perhaps, obstinate constipation. The ratio of recoveries without operation is eighty per cent., and with operation, twenty per cent.

THE REMOVAL OF FACIAL BLEMISHES BY ELECTRICITY.

WILLIAM HARVEY KING, M. D.,

NEW YORK.

There may be some physicians that think this subject is one that is intended to appeal to the sentimental, rather than the useful, side of surgery; but, so far as I can see, the forte of the physician is to relieve suffering, no matter whether it be from a facial deformity or a club foot. I have seen by far more suffering, more exclusion from society, and the life of patients and those surrounding their home life made more miserable by the superfluous growth of hair on women's faces than I have from all the fibroid tumors I have ever seen, and yet physicians are promiscuously recommending patients to undergo the

most hazardous operations for the tumors, and only laugh at and ridicule the patient who applies for the removal of the hair. The physician who realizes that the chief burden of life is made up of little things comes far nearer the ideal physician than does he who ignores the little things and only sees the glory to be won in the larger operations, or ignores all which does not come under the head of physical necessity. Some one may say that it sounds too much like quackery; but remember that, if the medical profession was the profession it should be, quacks would not exist, and the fact that this is one of their largest fields, if not the largest, proves that in this very branch it is most deficient.

In order that we may fully understand the process of destroying the hair growth by the electric current, it is necessary that we should understand the formation of the hair follicles and the action of the current upon them. An ordinary depilatory applied to the surface will loosen the hair so that it can be removed with the same ease that it can when operated on by the electric needle, but it will immediately return, larger and stronger than before. It is, therefore, evident that the killing of the hair does not permanently remove it, but that part of the follicle which forms the hair must be destroyed.

The hair follicle is formed by three layers of cells, an internal one, which is a homogeneous structure, similar to the transparent membrane formed between the rete malpighii and the corium; the middle layer consists of connective tissue, with its oval nucleus imbedded into a granular substance; the external layer is fibrous and contains most of the blood vessels and nerves of the follicle. It is claimed by some that the inner layer furnishes the nutrition, the second or middle layer the cells and papilla, and the external the pigment or coloring matter for the hair. Others differ slightly from this view, but all agree that the middle layer is absolutely essential to the formation and growth of the hair. It is, therefore, necessary, in causing the destruction of hair growth, to destroy this middle layer of cells.

When we come to consider the process of electrolysis I wish to correct a mistaken popular idea, that electricity, by its inherent magnetic power, causes destruction. Electricity only produces destruction by the caustic alkalies which it sets free at the negative pole and the acids, etc., that it sets free at the positive pole. One very important point which should be understood is that these alkalies and acids form evenly on all sides of the electrode that is introduced into living tissue, and that it is held in position by some force, the needle being the center of this force, the same as the earth is the center of the force in gravity.

If an alkali of similar composition could be introduced into a hair follicle and held in position, the action would be the same as the polar action of the current. This fact having been recognized, there has arisen a method of destroying hairs by carrying into the follicle a solution of caustic potash; but the difficulty of carrying the solution to the depth of the follicle and the inability to always control its action, thus causing at times destruction of tissue which was not intended to be destroyed, has made the method unpopular.

The paraphernalia needed is a galvanic battery which is capable of giving off 8 to 12 volts, and one that the voltage is comparatively large per cell, such as the red acid or LeClanche cell, as it will be less painful than if the cells used are of very small voltage; a flexible hand electrode; a pair of epilation forceps and a needle and handle to hold it in. The two latter need special mention. The handle should be solid; that is, not containing an interrupter, as was formerly used and is recommended by some to-day, for the shock which is produced by closing the circuit after the needle is inserted not only produces more pain, but it also produces bad effects on the nervous system of susceptible patients.

Various needles have been recommended by different operators. The one which I prefer above all others is what is known as a jeweler's broach. These certainly possess one recommendation which no others do and that is cheapness, selling for about fifty cents a dozen, whereas the platinum and gold needles are very expensive, more cumbersome, possess no advantage over the broach and in many respects are not as good, for the very thin ones are so pliable that they are useless. After selecting a few broaches, varying in size, which is necessary in operating on small or large follicles, the sharp point should be removed and the rough, square surface rounded down to a blunt point, which is only the work of a few minutes on an ordinary oilstone. This is the only preparation needed. The bulbous point recommended by some is not necessary, nor is it necessary to draw its temper, for one who has not the steadiness of hand to introduce the needle as it is without the slightest danger of breaking it had better leave the operation alone, but I wish to emphasize the importance of having the needle blunt-pointed. It can be seen that a sharp pointed instrument would glide through the side of the sac so easily that it would not be perceptible to the operator, whereas the blunt pointed instrument would follow the hair, the walls acting as a guide for it, also when it has reached the bottom of the sac it will stop and require some little effort to push it beyond this point, while the sharp pointed instrument would

penetrate the bottom of the sac without the perception of the operator and thus electrolysis would be produced in tissue which is not only unnecessary, but injurious.

The technic of the operation.—The flexible hand electrode is well moistened and placed in the patient's hand or on some convenient part of the body. If the patient is particularly sensitive, it may be laid in some convenient place and, after the needle is introduced the patient gradually puts her hand on it, first the tips of the fingers and gradually let the whole palm of the hand down on it, and, when the process has been carried far enough, she can as gradually raise her hand, thus avoiding the disagreeableness of the slight shocks that occur on introducing and withdrawing the needle, which are really cathodal closings and openings. This, however, all takes time, and it is only necessary with particularly sensitive individuals, for, with the majority of cases, this is not complained of, after the first few hairs have been removed. The needle is introduced down alongside the hair to the bottom of the sac and no further. This introduction of the needle is the all-important part, so far as the success of the operation is concerned, and the experienced operator will depend more on the sense of feeling than on his sight. If the needle is in the follicle, it glides smoothly along with but very little pressure until it reaches the bottom ; but, if it should not enter the follicle, it will require considerable pressure to make it go through the epidermis, when it will suddenly slip further in, accompanied usually by a slight crackling noise.

As regards the number of cells you turn on, it depends upon the amount of resistance you have in the circuit and the strength of the cell you are using. If the surface electrode is held in the palm, four to six Le Clanche cells may be needed ; if it is placed on the back or chest, it will not require quite so many, as the resistance will be less, but from two to four milliamperes should be used. I am sorry to say that the M. A. Meter cannot be used as a reliable guide, for it is not generally correct enough for such small measurements. An instrument which would be absolutely correct on large measurements might, from a lack of sensitiveness, fail here. In ascertaining the strength of the current required, one rule should always be followed; begin with the minimum amount and gradually work up to the strength required. If you should unduly shock your patient on the start, you are very liable to destroy her confidence and get her into such a nervous state that the operation will be much more difficult. The length of time the needle should be left in the follicle varies with the strength of current used and the amount of moisture in the follicle. The greater the

strength and the greater the moisture, the shorter will be the period. Usually from one-half to three-quarters of a minute will suffice. A little frothy substance will usually be seen around the needle. There is no peculiar appearance of the hair or the surrounding tissue, unless the electrolysis is carried too far, to indicate that it is time to withdraw the electrode; but experience will soon teach one to guage it correctly. After the needle is withdrawn, the hair should be removed by a pair of small forceps. If it is removed easily, the follicle is sufficiently destroyed and the hair will not return; but, if it requires some force to remove it, the hair is not dead, so to speak, and the needle should be reintroduced and the current applied again. I have constructed for my own use a pair of forceps that are so delicate in grasp that they will not remove a hair unless it is perfectly dead.

As regarding the pain, I would say that I have never had a patient abandon the treatment on that account, although some have apparently suffered much from the treatment, while others do not mind it in the least. It differs entirely with the degree of sensitiveness of the patient. The ointments containing cocaine and menthol which have been recommended as a local anæsthetic are useless. The same can be said of the ether spray. The hypodermic injection of cocaine relieves the pain in a small area for from ten to fifteen minutes, but it is only practical for those cases where a few hairs are to be removed from a small space, such as a hairy mole. If the operator is careful, taking a little longer time, he will not have much trouble in getting the patient to bear all the pain necessary.

Some patients are so constituted that the electric current produces very bad effects on them. It is due to some idiosyncrasy and is not only noticeable in this, but in all forms of electrical treatment. In such a case the sittings should be of short duration, a very weak current used and the positive electrode should be placed on the chest or back, as close to the face as is practical, so that there is as little electricity distributed through the system as possible.

As our object in removing the hairs is to get rid of a disfigurement, it is very essential that we should not cause another disfigurement by the formation of scars. It is only necessary in order to successfully remove a hair, to destroy a microscopical amount of tissue, consequently the scar tissue is microscopical and is not visible to the naked eye. It sometimes happens that the root of the hair runs in a different direction than the hair would indicate. In such a case, it is very difficult to introduce the needle into the follicles. The tendency is to re-introduce the needle alongside the hair several times until quite a circle of

tissue is destroyed. It is always better to wait and try and remove the hair at some other sitting.

Another cause of scars is, when hairs are removed so close together that the destroyed tissue of one follicle runs into that of another. If enough of these should be close together, a large, dark spot will be left and, consequently, a visible scar remains. This can be easily guarded against by not removing hairs situated closely together. This same principle applies to too frequent operations. Treatments should not be made on the part of the face that has been treated until it has entirely healed, which will take from four days to a week. Of course, if the face has not been entirely gone over in the previous treatment, that part which has not been touched can be treated the next day, if the patient is in a hurry.

Regarding the after treatment of the operation I would say that I have tried various things, and I now simply rub a little talcum powder on just after finishing the treatment and instruct the patient to do so every morning.

Undoubtedly, even with the best operators, there are some hairs that return but, with due care I believe this can be reduced to five per cent. and even less.

It is claimed that the electric current stimulates the growth of hairs and that many more are made to grow by this treatment than would if left alone. If the hairs are all large and coarse and not interspersed with a growth of down, when the coarse hairs are removed there need be no fear of any others coming in; but when there is a heavy growth of down mixed with the coarse hairs, I think the tendency is for the downy hairs to slightly increase in length after the coarse ones are removed. They are, however, easily removed, as the follicles are so shallow, and the fact that the down does slightly increase in length should not in the least deter any one from treating such a case. One thing should be borne in mind and that is that this treatment takes time, and, unless the patient can come back within the following year to have the few returning hairs removed, she must be made to understand that she will not have a perfectly clean face.

Nævus Vasculosum. It is necessary to make one classification of the various forms of nævus. That is, the elevated and non-elevated, as the two require different forms of treatment. Without giving a treatise on the subject of electrolysis, I wish to make a few remarks concerning it in order that an intelligent understanding may be had regarding the various points involved in their treatment. You will remember that caustic alkalies, etc., are set free at the negative pole

and acids and chlorine at the positive pole. If we introduce two needles connected with the respective poles into healthy tissue and allow a current to pass strong enough and long enough to produce destruction and then allow these to heal, we will find that two scars remain, varying in size according to the amount of tissue destroyed. If we watch these scars for some months, we will find that the one produced by the positive pole very soon turns white, sinks slightly below the surface and contracts until it is a hard, cicatrical spot and looks badly. On examining the scar produced by the negative pole we find nearly the opposite conditions. It is liable to be elevated above the surface of the skin and remain red and irritable. It will, therefore, be seen that if we get the proper amount of action of the different poles the scar will not be depressed, contracted and unduly white, or elevated, red and irritable.

Now, in removing a nævus, the most important thing is to do so thoroughly and permanently, but yet leave as little disfigurement as possible. It is here that the proper balancing between the two poles of the battery comes in. Of course, this is always a matter more of judgment than anything else, but a few rules will help very much: First, the temperament of the patient should be our guide. If the patient is plethoric, the action of the positive pole should predominate, and, if of a thin, anæmic character, the negative should. Second, the deep-seated nævus requires the predominance of the positive pole and the superficial the negative. Third, the age of the patient. A young active person requires more of the positive pole than the negative. Fourth, the character of the tumor. The bright red, arterial nævus requires the predominance of the positive pole, while the dark, venous ones will usually require the predominance of the negative. Fifth, the location. If the tumor is situated on that part of the face where it is exposed to the cold blasts of air or subject to irritation of any kind, the positive pole should predominate, for the negative scar is congested by the least irritation.

Great care should be exercised in introducing the needle into the base of the tumor. One point which should be carefully looked after is to see that all the disease around the edges is thoroughly destroyed, leaving nothing but healthy tissue; for, if any of the nævus tissue is left, if it does not act as a nucleus for the reproduction of the tumor, which it is liable to do, it will make the scar much worse, leaving the edges rough and elevated, and in one case I have seen it prevent the growth of the integument over the place, thus leaving an unhealed spot for months. On the other hand, one should be careful not to

destroy more tissue than is absolutely necessary, for the scar will be greater. The needles are introduced at the base of the tumor, parallel to the surface, and not under the tumor, but so near the bottom that the destructive influence will destroy it entire. It will be remembered that the destructive influence of the current is the same on all sides, so the amount of tissue destroyed underneath the needle can be judged by the amount that is acted on above the needle; hence it becomes very necessary to diagnose the depth of the tumor before introducing the needles. If both needles are to be introduced, and this will be the case unless you should wish to get the action of one of the poles exclusively, the positive needle, which should always be of platinum or gold, should, if possible, be introduced over the orifice of the principal vessel supplying the nævus, for the eschar produced by the positive pole is firmer and is not liable to be absorbed by the pressure of the circulation, as is the case with the soft, negative eschar. If the nævus is located where the bone comes near the surface, such as over the molar bone, great care should be exercised not to set up an inflammation of the periosteum, for, if this is done, the whole surrounding tissue becomes adherent to the periosteum and leaves one of the worst looking scars that can be produced. The after treatment is very simple. A piece of iodoform gauze may be strapped over the eschar and changed as often as the circumstances may require. When the slough comes off the sore should be kept clean and dressed with iodoform or zinc ointment, and, if the operation has been thoroughly performed, it will heal rapidly. There is a kind of tumor which is classed as a nævus which requires a little different kind of treatment, and that is where there is a smooth integumentary growth over the plexus of vessels. The idea here is to destroy the plexus of vessels without producing a slough. This is a very difficult thing to do. The needles should be so insulated that there is no electrical action around the seat of the puncture in the integument. The needle attached to the positive pole should be of platinum or gold and of large size. It should be introduced through the center of the tumor and left in that place. The negative needle should be smaller and inserted first on one side of the positive and then on the other. The process should be continued until the whole tumor has a hard, elastic feeling, but no discoloration should take place. It should be carefully watched and if within the first week, there are signs of softening, the operation should be repeated immediately; but, if it remains hard for one week, the disease is generally cured. Some cases have a great tendency to return and, after several attempts, you may be forced to produce a slough in order to get rid of the disease.

The flat, vascular nævus (port wine mark) is removed in a somewhat different manner. Under this same head may be included pigmentary nævi, moth patches, etc. It should be understood that the same principle governing the selection of the respective poles should apply here as it did in the other form of nævus. Instead of performing electrolysis of the base, we simply puncture into the nævus, the punctures being about one-sixteenth of an inch apart, and the electrolytic process continued until the action around each of the needles coalesces with its nearest neighbor, thus making a continuous patch. It is generally best to introduce the poles alternately, positive, negative, positive, etc. A slight puncture should be made as the electrolytic process is carried on beyond the point of the needle the same as it is around it. The same caution regarding the edges of the nævus are just as applicable here as they are in the elevated form, although it is not quite so necessary as it will not prevent its healing. It is, however, important that the new integument which is to cover the surface should start from healthy borders.

If the navæus is large, several operations may be necessary before the cure is completed, allowing one to heal before another is attempted. The operation is not painful and can easily be done without an anæsthetic. The method recommended by some, to first blister the nævus and produce electrolysis on the surface by a blunt instrument, always leaves a very bad scar and, to my mind, should never be employed. Warts, fibrous growths and moles come under the same head as elevated vascular nævus, and the rules given under that heading will suffice here.

However, when a mole has hair growing in it, (nævus pilosus,) the hairs should first be removed and then wait for it to heal, when it will generally be found that the mole has been removed also, but, if perchance it has not, it will be an easy matter to remove what is left.

Scars. It should be understood that I do not pretend that a scar can be wholly removed; but the very bad looking scars can be greatly improved. It is well known that it is the natural tendency of cicatrical tissue to turn white and contract, and it is to remove the deformity of the contraction and to a degree the pearly whiteness that is the object of the treatment. If the scar is elevated, it should be removed the same as elevated nævi, and the same laws governing the selection of the poles should be applied. But those scars which are depressed and have contracted lines running through them require a somewhat different treatment.

The treatment consists in a combination of negative punctures and

dry cupping. First all the contracting edges should be punctured with a fine needle connected with the negative pole. There should not be the same amount of tissue destroyed that is necessary in operating on port wine marks; only the slightest eschar should be made. We depend as much upon the osmotic effect by the setting free of bubbles of hydrogen, etc., to break up the tissue, as we do the formation of new tissue. After the scar has been scarified in this way, a dry cupping instrument is placed over it and slight suction made. This is for the purpose of drawing blood to the parts, which increases the size of the vessels, and, consequently, increases the nutrition to the parts. This treatment may be given at first once a week or even oftener, and, as the scar improves, the intervals may be lengthened till once in three months may be sufficient.

In conclusion, I wish to state that all of this treatment takes time and the patients should be so informed, for they are always impatient and will get more so if they are not made to understand that they must be patient.

PROMISCUOUS CASES IN GYNÆCOLOGY AND SURGERY.

HARRISON WILLIS, M. D.,

BROOKLYN.

CASE I. Mary Carrogg, about sixty years of age, was admitted to the Cumberland Street Hospital, in September, 1891. She had been flowing for four years almost continuously, using on an average three or four napkins a day. The discharge was very offensive. The uterus somewhat prolapsed, was movable and enlarged, so that a sound could be passed in five inches. The cervix was apparently healthy. She was curetted several times, and a large amount of broken-down tissues removed. This was followed each time by considerable hæmorrhage. Specimens of the débris were examined by Professor Blackman microscopically, who confirmed my diagnosis, which was epithelioma of the body of the uterus. October twenty-third vaginal hysterectomy was performed in the following manner: The womb was drawn down so that the cervix protruded externally, then a curved sound was passed into the bladder to ascertain how low it was attached to the uterus, then making sure that I was safe below the attachment, the knife was

carried through the mucous membrane of the cervix anteriorly from side to side, say an inch in length. Into this incision my fingers were inserted, and the membrane peeled from the anterior surface of the womb. It has always been a cardinal principle with me in surgery, never to use a knife or other instrument to do what could be better done with my fingers. The cervix was then drawn forward, and a corresponding incision made posteriorly, and the mucous membrane peeled off in the same manner.

It will be understood that on each side of the cervix there was left a piece of the mucous membrane intact; now, with one forefinger anteriorly and the other posteriorly hugging close to the uterus, the membrane was separated on either side as much as possible without using too much force. This was carried up one or two inches, then with a threaded aneurism needle, strong ligatures were passed round the unseparated portions on each side and firmly tied; these included all the blood-vessels which supplied the uterus, which was then cut away about a quarter-of-an-inch inside the ligatures. The womb was now fully separated from its remaining attachments by the fingers. The peritonæum instead of being cut was torn. In drawing the cervix forward the parts were in such an advanced stage of degeneration that, though little force was used, the cervix was separated at the internal os. This, of course, expedited the removal of the fundus, which was retroverted and dragged down by forceps, the tubes and ovaries pulled down and clamped by Polk's forceps, and everything cut away close to the clamps. A wad of iodoform gauze was introduced and the forceps left in. The patient made a good recovery, remaining in bed about four weeks. She had very little rise of temperature, in fact suffered far less after the operation than before.

The only occurrence worthy of mention was that at the end of forty-eight hours, I removed one of the forceps; this was followed by quite a hæmorrhage, which stopped without assistance. However, hereafter, I shall not remove the clamps until the end of seventy-two hours. The patient left the hospital cured January 5, 1892. She called on me last June, when I made a careful examination; she seemed well, is now in my employ, and is a faithful and efficient servant. She says she never enjoyed better health in her life than at present.

CASE II. Mrs. Eliza Johnson, age forty-three, a native of Sweden, was admitted to the hospital July 4, 1892, to be treated for lacerated cervix and rectocele. As the cervix appeared to be in a very unhealthy state, she was treated locally by Dr. Sage, house surgeon, for several weeks with but little benefit. I examined her on August 12th, and

discovered that she had, in my opinion, an epithelial cancer of the cervix, extending up to the internal os. She was curetted and specimens given to Dr. Ensey and Professor Blackman for microscopical examination. They decided that the growth was malignant. After consulting with the other surgeons of the hospital, vaginal hysterectomy was performed on August 26th. The patient made a rapid recovery; she was sitting up at the end of the third week, her highest temperature was 101°, and highest pulse 100. She was discharged cured September 27th.

Now I wish to say one word in regard to the open treatment of amputations. I believe it is the safest in all cases, washing out the wound two or three times a day by irrigation with pure water, a weak solution of bichloride of mercury or carbolic acid, probably the more pure water and the less solution the better.

For the last ten years, or since the Listerian craze, the majority of my cases have been treated by using all the so-called precautions of Lister, or rather I have commenced with that treatment, but whenever the temperature ran up to 103° or more, during the first few days, as they frequently have, the stitches were taken out, the wound pulled open, and kept open till it healed, and it has been almost wonderful to see in how short a time the temperature and pulse have dropped down to nearly normal. In such cases we would often find that small clots of decomposed blood completely studded the surfaces of the wound. I will put it down as a rule not to be departed from, never to close a stump if there be any oozing of blood or if the flaps are diseased or injured so that there is danger of sloughing. The only advantage I have ever found in closing the wound and getting union by first intension, is that it looks better at the time, but you get on an average a much quicker cure by the open than the closed method, as I have proved to the satisfaction of others, as well as myself many times.

CASE III. W. B. Aikins, aged twenty-nine, was admitted to the hospital August 2, 1892. The following is the history of the case as given to us. About four months before he felt a severe pain in the under side of the left knee, the pain increased and he was confined to his bed. In regard to his previous treatment, I was not thoroughly informed, Dr. C. L. Bonnell, who was the surgeon on duty, and I, saw him first on his admission to the hospital. He was as emaciated as any one I ever saw in the last stage of phthisis. The thigh was drawn up, and the leg flexed at an acute angle. A large abscess occupied the whole of the inner side, and front of the thigh, from Poupart's ligament, extending round to the popliteal space; another

one occupied nearly the whole calf of the leg. These abscesses were discharging nearly a quart of pus per day, according to the best information I could obtain. We notified his friends that we would have nothing to do with the case unless we could amputate the limb if we found it necessary. We were given permission to do whatever we thought proper. On August 4th, he was taken to the operating room and anæsthetized. I took hold of the leg and gently attempted to straighten it, when I had brought it to a little more than a right angle, a gush of arterial blood spurted from the open sinus of the abscess. I had ruptured the popliteal artery. Whatever hope we had ever had of saving the limb was now gone. I instantly compressed the femoral artery with my thumb. An Esmarch bandage was firmly applied and the limb amputated by Dr. Bonnell at the juncture of the upper and middle thirds of the thigh. It was found that the abscess had burrowed beneath the femoral artery its whole length. The stump was treated openly. Before the operation, the temperature was 99.6°, pulse, 110; six hours after the temperature was 96.6°. August 5th, eight A. M., temperature 97.6°. From August 6th to 12th, temperature averaged about 100°, and pulse 110. We found on examining the joint, that there was necrosis of the lower end of the femur, including the whole articulation, the patella was also necrosed. Sinuses were radiating in different directions. The popliteal space was one conglomerate mass of diseased tissues. My slight attempt to straighten the limb had ruptured the artery, vein and nerve. The patient made an uninterrupted recovery, and was discharged hale and hearty with the stump nearly healed on September 27th.

CASE IV. Joseph Heritage, age thirty-four, a native of England, was admitted to the hospital, July 17, 1891, suffering from cellulitis of the right thigh, leg and foot, he had wrenched his limb some months before, but attributed his trouble to an attack of grip which he had had the previous winter. Large abscesses formed in different parts of the limb which were opened and drained, when others would form, and this continued for months; then when the thigh and leg were better his foot became worse, and vice versa, till finally we could see no hope of his ever having a useful limb. We then advised that it should be taken off, which he declined and left the hospital June 20, 1892. He came back on August 17th. The limb was then amputated at the upper third of the thigh, the stump was treated openly and irrigated twice a day; first with bichloride solution, then with peroxide of hydrogen. He made a good recovery and was discharged cured September 29, 1892.

CASE V. A. W. Collier, aged twenty-two, was taken into the hospital April 1, 1892, though the recommendation of Dr. McFarland, of Woodhaven. His history was that two years ago he was thrown from a train while acting in the capacity of brakeman, and fell astride a high switch, injuring his testicles, but nothing could be discovered by examination that appeared abnormal. He complained of having nightly emissions and was very despondent and nervous, complaining of constant numbness in his left side, and pain in his testicles. He had consulted many doctors and been in several hospitals, and insisted that he should be castrated. A consultion was held with my associate surgeons, who decided against the operation; in the meantime he got much worse mentally; when the case was referred to Dr. W. M. Butler, who decided first that medicine would do the patient no good; secondly, that if castration was not performed very soon insanity would certainly ensue. Double castration was performed April 21st. April 22d, he felt very happy and pleased with his condition; May 19th he was discharged cured, leaving a letter expressing grateful thanks for what we had done for him. Quite recently he informed his physician that he was well and was very glad that the operation had been performed. I have related this case partly on account of its uniqueness and partly to point out that while there is little doubt that castration has been performed too frequently in one sex it is barely possible that it has not been done often enough in the other.

CASE VI. Ectopic Pregnancy. September 28th, I was called in consultation by Dr. Terhune, to see Mrs. Lynch, aged twenty-nine, of 293 Reid avenue. He gave me this history of the case. She had been married nearly five years, had two children, the younger less than two years old, and had two miscarriages previous to having the children. She had been pregnant about four months, her last menstruation being on the 28th of May; five weeks ago she was taken with a severe attack of vomiting with great pain in the bowels which was diagnosed by the doctor attending her as cholera morbus; she got better in two or three days, so as to go about the house. One week later she was taken with violent pain in the abdomen and sank into a collapsed condition, and remained in a very low state, until Friday, September 5th, when Dr. Terhune first saw her. She had then rallied but had a high fever and indications of peritonitis; she had labor-like pains and passed shreds of mucous membrane with blood and mucus. He was of opinion that she was having an abortion and that the os had closed tightly on the contents of the womb. I found the patient was considerably emaci-

ated, had an anxious expression, was suffering much pain; her pulse was 110, and temperature 102°. Passing my hand over the abdomen which was very sensitive, I found a tumor extending upwards two inches above the umbilicus occupying the whole abdomen below, a little more to the left side than the right, but from external examination, it closely resembled a pregnancy of seven months. On making a vaginal examination I felt the os and cervix, which appeared not unlike the cervix of a normal uterus; I gently passed my fingers into the Douglas cul-de-sac, that also seemed in a normal state, no tumor could be felt there. The uterus seemed somewhat immovable. What was the matter with the patient? She had an abdominal tumor, but what was it? She had undoubtedly been in a collapsed condition four weeks before. What did that mean?

I have read Lawson Tait's book on abdominal surgery and noticed where he advocates laparotomy for reducing a strangulated hernia by pulling the gut in, by getting hold of it on the inside. I do not think he has given that matter enough consideration and he will probably change his mind when he has had a little more experience in strangulated hernia; but in what he has written on ectopic pregnancy, he is undoubtedly an authority and the only authority we have on the subject of any real worth, so I thought this must have been a case of tubal pregnancy that at about the end of the twelfth week had ruptured within the fold of the broad ligament extra-peritoneally. I communicated my diagnosis to Dr. Terhune and the friends of the patient, and told them that though I might be mistaken, at any rate whatever it was, an exploratory incision should be made as soon as possible. I also advised that the patient should be taken to the hospital, to which they agreed. A consultation was held there at three P. M. My colleagues did not dissent from my diagnosis, and it was decided that an exploratory incision should be made at once. The patient was anæsthetized and taken to the operating table. The incision was made in the median line between the umbilicus and pubes about three inches in length. When the peritonæum was reached, marked indications of inflammation appeared so that I could hardly tell whether I had gone through the peritonæum or not, but I soon discovered that the tumor was firmly adherent to the parietes all round the incision. After feeling that there was fluctuation indicating fluid immediately beneath the thin wall of the tumor, a small trocar was pushed through it when a dark, thick, tarry substance, very offensive, passed through the canula. As it was evident that the adhesions would prevent any of the tumor contents from entering the peritoneal cavity, the instru-

ment was withdrawn and an incision made, large enough to pass two of my fingers within the tumor. This allowed its contents which were evidently decomposed blood, to flow out very rapidly. Quite a little gas escaped with the fluid. This accounted for the resonance we had noticed when examination was made by percussion. On passing my fingers within, the first thing I really distinguished was the fœtus, which was removed. It was about the size that would indicate a three months' pregnancy, and had probably died when the rupture of the tube occurred, it was attached by a small umbilical cord, the size of a knitting needle; this was cut, the cavity was washed out with pure water by irrigation, no attempt was made to clean it in any other way. During the washing out, I was examining the cavity with my fingers. The fallopian tube and placental attachment seemed to have been carried up a little to the right of the navel and to that point the fœtal cord seemed to be attached. I also found what I thought to be the distal end of the left fallopian tube attached about the same place. On making a bimanual examination, the fingers of one hand being within the incision, I could distinctly feel the womb which was denuded and about the normal size. I also ascertained that the tumor cavity extended to the left ovarian region. The amount of fluid in the cavity must have been nearly three pints. The after-treatment consisted simply in putting a large rubber drainage-tube extending to the bottom of the cavity, and closing the incision with deep stitches extending through the wall of the tumor, and the cavity was irrigated once or twice a day with a solution of bichloride 1 to 5000. The patient did not suffer from shock to any extent; the lowest temperature was 97.6° The next morning the temperature was normal. In the afternoon it went up to 102°. The highest temperature was on the third day when it reached 103.8°. She has had no nausea, and has been eager to eat all that was given her. Her bowels moved naturally on the fourth day. She has had no opiate, and has been treated homœopathically by Dr. Sage. October 4th, her temperature was normal, as it had been for the last two days, pulse less than 100 November 3, patient discharged from the hospital cured.

REPORT

OF

COMMITTEE ON LEGISLATION.

THE SITUATION AT MIDDLETOWN.

GEORGE ALLEN, M. D.

First Assistant Physician at the Middletown State Homœopathic Hospital.

The homœopathic profession of the State of New York has always been interested in the progress of the Middletown State Homœopathic Hospital. The State Homœopathic Medical society was largely instrumental in its establishment, and has many times exerted a potent influence in its behalf. As the result of recent lunacy legislation, conditions have arisen which seriously affect the Middletown hospital and the privileges therein, which of right belong to the adherents of homœopathy throughout the state. Therefore, a statement of the condition in which the Middletown State Homœopathic Hospital finds itself at the present time may not be without value as a means of information, as well as for guidance in any action which the homœopathic profession may feel disposed to take in the premises.

A thorough understanding of the subject demands that it be historically considered. To this end inquiry should be made as to the causes which led to the establishment of the hospital, the character of the institution which its founders intended to establish, and the manner in which their intentions were carried out. In pursuing these investigations it will be found that at a certain stage in the progress of events the State assumed charge and, by legislative enactment, undertook to complete the institution and provide for conducting it as a homœopathic asylum in accordance with the plans and intentions originally set forth by its founders. It will be seen that the state completed the erection of buildings, and has conducted the institution in accordance with the original designs during a greater part of its history, and that only lately has this design been departed from through

the influence of recent legislation. The pernicious influence of such legislation will be disclosed and its effect in interfering with the legitimate work of this hospital, by diverting it from its original purpose, thereby occasioning injury to the unfortunate insane, as well as great injustice to the homœopathists of this commonwealth.

A quotation from a circular issued in December, 1869, by Dr. Geo. F. Foote*, will perhaps, as clearly as anything, set forth the causes which led to the establishment of the Middletown State Homœopathic Hospital. "The homœopathic practice of medicine in this country alone now numbers over five thousand physicians (they now number about twelve thousand), while its recipients and believers are numbered by many hundreds of thousands. These are from the most intelligent and respectable portion of the community, people of good sense, good judgment, in every way competent to distinguish between right and wrong. They represent all professions, trades and arts, and their numbers are increasing at a rate that is in harmony with the progressive age we live in, affording abundant evidence that this great system of medical reform is one of the powers that promote the happiness and well-being of mankind. * * * We have colleges for the instruction of those who aspire to the healing art; we have dispensaries and hospitals where the unfortunate sick may receive proper medical attention; but we have no asylum where the sick insane can receive the blessings of homœopathic treatment."

Here, then, is clearly stated the cause which led to the establishment of the Middletown State Homœopathic Hospital. It was the clearly felt want, by the adherents of homœopathy, of a homœopathic asylum for the insane. The circular from which the foregoing quotations have been made was addressed to what may be called the homœopathic public—those who, when sick in body or mind, preferred to be treated by the homeœopathic system of medicine. The circular still further voiced the reality of this want as follows: "Is it not an alarming reflection that any member of our households, a bosom companion, or our children, if attacked with this disease, must be hurried off to an asylum where allopathic treatment reigns supreme? Is it not alarming, when we reflect that there is no retreat, no home, where, if necessity requires, they can be sent and receive that benign treatment our long experience has taught us is so efficacious in curing the sick?"

This circular was issued by those who felt the necessities of the situation as it then existed, and those addressed were importuned as follows: "We must talk about it in our homes, in our offices, upon

*Transactions Homœopathic Medical Society State of New York, 1869, p. 420.

the street corners, and among our patrons. We must give from our own stores, and gather from the overflowing coffers of our friends." This is precisely what was done. The matter was agitated, and the work systematically undertaken for the establishment of a homœopathic insane asylum. Then followed discussion, and the determination of the character of the institution which it was proposed to establish. The original design contemplated an institution founded by money contributed by the friends and patrons of homœopathy; the current expenses to be paid by the patients, each in proportion to the rooms occupied and the attention given; the superintendent and officers to be salaried, and to have no pecuniary interest beyond this; the whole to be under the control of a board of trustees. It was distinctly set forth at that time that an asylum so organized would be "accessible to a large class of respectable citizens who are able and willing to pay current expenses, but are not able to pay extravagant prices." At the same time it was stated that such an asylum would be equally available to the more wealthy who could receive the attention and be accommodated with quarters commensurate with their ability to pay. It was to be "to all intents and purposes a respectable charity" where occupants and their friends could feel that they were "rendering a *quid pro quo*." It was not proposed to make the enterprise in any sense a stock company with a prospect of dividends; on the contrary all receipts were to be used for the welfare of the inmates, and if this were done it was believed that the institution would have a right to participate in such legislative disbursements as were made from time to time to similar institutions. It was even claimed at that time that the homœopathists had "a right to demand that a public asylum be set apart" to their management. These claims were made on account of the superiority of the homœopathic system, and because the large numbers, the wealth and influence of the homœopathic adherents justified them in making such a demand.

The work of raising money went on; public meetings were held, a location was decided upon, land was purchased, and the erection of a building begun. The historical records at this point are by no means complete, but this much is known: that those who had the matter in charge thought best to turn the project over to the State for completion. This was done, and in 1870 the Legislature passed an act establishing "The State Homœopathic Asylum for the Insane at Middletown." This was the charter of the institution, in granting which the State accepted the moneys already raised, and the land (two hundred acres) already purchased by the friends of homœopathy, and granted

to the citizens of this commonwealth a state asylum for the treatment of the insane by the homœopathic system of medical practice. In so doing the State adopted the plans of those who had the matter in charge, and undertook to have the same carried out under State supervision. As we have seen, this implied an institution where those of moderate means could obtain care and treatment at cost, where counties could send their insane for care on the same terms, and where the wealthy could obtain care and accommodations "commensurate with their ability to pay," and in accordance with the necessities demanded by their previous manner of living, always presupposing that the insane person or his friends elected that he should receive homœopathic treatment. There was nothing in the charter or in existing laws which precluded the establishment of an institution to be conducted upon such a plan. Under the charter thus granted the work was carried on, the necessary buildings erected, the State fulfilled its part of the obligation, and the Comptroller paid over from time to time such sums as had been agreed upon as the conditions were met. In April, 1874, the asylum was opened for the reception of patients. From the opening of the institution the plan upon which it was conducted was essentially that laid down by its founders. There were received from all parts of the state insane patients who desired homœopathic treatment; these included persons of moderate means and those who were wealthy, as well as those for whom payment was made by the county in which the patients resided. The Legislature added to the charter from time to time, making more secure the strictly homœopathic character of the asylum, or provided greater facility for sending homœopathic patients from the various portions of the state to the homœopathic asylum.* For several years the number of patients was comparatively small. But as the results of treatment under the new system became known, people acquired confidence in the new institution, and it soon became self-supporting, and since about 1877 the Middletown hospital has not received a dollar from the state for maintenance. As is well known, homœopathy counts among its adherents many of the wealthier class of citizens. Numbers of these sent their insane friends to the Middletown asylum for treatment, and with the liberal payments received from such patients the trustees were enabled to add to the beauty of the grounds, and to provide much in the way of internal furnishing and decoration without expense to the State. In this manner the property of the State has been greatly enhanced in value, and the comfort of the patients has been materially increased. While

* Chap. 414, 1874, and chap. 121, 1876.

doing all these things to cheer and alleviate the unfortunate insane, and to beautify and render more comfortable their surroundings, the trustees were enabled from time to time to reduce the price paid by the counties till the weekly price charged by the Middletown asylum for the care of county cases was lower than that charged by any other asylum for the treatment of the acute insane—viz.: $3.75 per week.

During the history of the hospital up to the opening of the present month, 3,629 patients have been admitted, 2,775 have been discharged, of whom about fifty per cent. have been recovered, while the proportion of deaths has been relatively small. Such results as appear have been attained by the maintenance of strictly homœopathic treatment.

The State from time to time has provided such buildings as were needed for the increasing number of patients. Comfortable and commodious day-rooms have been built, designed to afford change of scene and an increased facility for fresh air and sunshine which could not fail to be of benefit to the patients. A pleasant and attractive schoolroom has been provided where, under the guidance of a teacher and companion, the unfortunate victims of mental disease are led away from the unwholesome surroundings of their own perverted and distorted imaginings, and conducted through the pleasant by-ways of literature, or interested in sterner problems of science. A commodious amusement hall and chapel have been erected, where dancing and entertainments of various kinds are conducted for the diversion of the patients on week days, and where on the Sabbath the patients are regularly assembled for worship. Greenhouses have been erected, mainly from the income derived from private patients, as a result of which the beautiful grounds about the hospital have been made more attractive by the thousands of plants of brilliant hues and flowering shrubs which everywhere greet the eye from early spring till latest autumn, while during the winter the weary sufferers upon the wards are often cheered by the presence of flowers which the hothouses supply. But greatest of all the good works which have been inaugurated at the Middletown State Homœopathic Hospital, and the one in which the management has greatest reason for pride, is the application of rest to the treatment of the insane. This institution was, we believe, the first to advocate the plan of enforced and prolonged rest in bed for the cure of insanity. This plan is in direct opposition to the teachings of many prominent alienists, but the results of the treatment have been so satisfactory that we believe it is destined to become universal in

the near future. In evidence of this, it is gratifying to hear that this method has, during the past year or two, been adopted in certain public asylums in Holland. The system of rest in bed for the insane necessitates hospital wards, which at Middletown are seen in large numbers, where many of the acute insane are gathered together in beds in large rooms, where they are always under the watchful eye of a number of careful and experienced nurses. Being in bed they are treated as sick patients, which they are. They receive frequent baths, massage, oil rubs, etc., and are looked after in all particulars as though acutely ill from some bodily disease. They are induced to partake freely of hot milk and other easily digested and nutritious articles of liquid food. As a result, the excited patient quickly becomes quiet, the depressed become more hopeful, the enfeebled in mind and body are tenderly cared for, and all are watched over in a better and more rational manner, we believe, than under any other system now in vogue. As a result of this method a majority take on flesh, which in so many is the physical precursor of a restored mentality.

The items of good work which have been enumerated have been the result of persevering toil along a given line during the period of the hospitals existence. It will be observed that this hospital has always occupied a unique position in the State's system of caring for the insane. Being the only homœopathic asylum, it belonged, more than any other could be said to do, to the citizens of the entire state. Other asylums could readily be assigned a given number of counties from which to receive patients, and no one would be injured thereby, for there still would remain a sufficient number of asylums to care for the other portions of the state. But not so with the homœopathic asylum. Once assign to it a district composed of a given number of counties only, and immediately an injustice is done to the citizens of all the other counties; for if they desire homœopathic treatment it becomes impossible for them to obtain it. The danger of such a condition of things arising was recognized by the friends of the Middletown hospital when the "State Care Act," with its districting plan, was before the Legislature. But upon inquiry, those who had the bill in charge assured the friends of that hospital that the rights which it had heretofore enjoyed as a homœopathic institution would not be interfered with. The act having been passed, however, a district composed of seven counties was assigned to the Middletown hospital—a district about equal in point of insane population to the districts assigned to each of the other state hospitals. A section of the law‡

‡Sec. 9, chap. 126, 1890.

provides that patients desiring to enter an asylum situated beyond the limits of the district in which they reside may do so in the discretion of the chairman of the State Commission in Lunacy and the superintendent of the asylum, provided there are accommodation to receive them. It was claimed that this clause would permit any who desired homœopathic treatment in whatever portion of the state residing to gain admission to the Middletown hospital. Apparently, this would be the case. Let us see, however, what has been the practical working of the law after a trial of something over two years. The Middletown State Homœopathic Hospital has been obliged to receive all public patients coming from seven counties comprising its hospital district. This meant all the public cases of insanity occurring in these counties during this time, for by the same law none of these cases could be sent to the county asylums as formerly, nor could any be transferred from the state hospital to the county asylums, or to the Willard or Binghamton asylums, so as to relieve overcrowding, as had formerly been done. All cases that come to the state hospitals now must be retained till cured or dead, so that it is only a matter of time before all our state hospitals must become full and overcrowding. This is precisely what has taken place at Middletown. During the two and a half years since the passage of the "State Care Act" this hospital has received nearly six hundred public patients. During this time the management has tried to accommodate also those persons from whatever part of the state who desire homœopathic treatment. That is, they have endeavored to obey the provisions of the "State Care Act," and at the same time carry out, as in the past, the intentions of the founders and of the Legislature which granted the charter of the Middletown State Homœopathic Hospital. Guided by this act of the Legislature, as voicing the will of the people who desired the establisment of this hospital, it has been the belief of the management that the Middletown State Homœopathic Hospital is and always has been a homœopathic institution to which those of the homœopathic faith should have the right of admission no matter who else may fail to enjoy that right. The time has arrived, however, when this hospital is unable to accord this right to the homœopathists of fifty-three counties of this state. The wards are sadly overcrowded; the beautiful day-rooms have been turned into hospital wards, and for some months have been crowded to a dangerous extent with the public insane from the Middletown district; the schoolroom has been put to a like service; wards intended to accommodate forty patients with comfort have been made to hold seventy; dining-rooms are over-

crowded, and inconvenience and distress are present to an unwholesome extent throughout the buildings. With a normal capacity of 675, this hospital has been made to hold 875 and more patients—a manifest impossibility without the presence of more or less suffering and distress. The result is that what was intended to be a hospital for the treatment and cure of the acute insane has become a place for the detention of crowded and uncomfortable masses, and a law which was intended to remedy an evil has become already the author of an evil of the same sort which it sought to cure.

By the condition of things above described, Sec. 9, Chap. 126, 1890, so far as it refers to the transfer of patients from one asylum district to another, has for some time past been inoperative, by reason of the fact that no "accommodations" have existed for the reception of patients from the fifty-three counties outside of the Middletown district. Therefore persons who desire homœopathic treatment at the Middletown hospital cannot be received, and what the law provided should be a homœopathic asylum for the citizens of the entire state is no longer so, for the citizens of fifty-three counties are denied admission and treatment within its walls. Already during the past five months applications to the number of more than seventy have been refused to patients from various parts of the state desiring to receive homœopathic treatment at the Middletown State Homœopathic Hospital. The State Commission in Lunacy promise that relief from the condition of overcrowding will be obtained in the course of the next few months by the completion of new buildings, and the transfer of Middletown's excess elsewhere. But what assurance can they give that the same condition of things will not speedily recur? Under the present system we see nothing to prevent it. Under the "State Care Act," with its present assignment of districts, the Middletown State Homœopathic Hospital is bound to become overcrowded with those who do not want homœopathic treatment to the exclusion of those who do. And whenever this occurs not only do the unfortunate inmates suffer, but that large class of intelligent, respectable, and well to-do citizens who are adherents of homœopathy all over the state must feel as they did in 1869 when Dr. Foote voiced their sentiments as follows: "We have no asylum where the sick insane can receive the blessings of homœopathic treatment." That statement was true then; it is true so far as the Middletown State Homœopathic Hospital is concerned in fifty-three counties of the state to-day. The homœopathists struggled, sacrificed and gave of their means for the establishment of the Middletown hospital. They have been loyal to

it; they have watched its growth and success with becoming pride, and now after so long a time they are practically as much without a Homœopathic State Asylum as though it did not exist. This state of affairs is the clear result of the new Insanity Law—the so called "State Care Act." It is not believed that it was the intention of the framers of this act thus to work injustice to their homœopathic fellow citizens; nor is it believed that the administration of the "State Care Act" under a fair and liberal interpretation, in harmony with other existing laws, need having occasioned the injustice and distress of which complaint is made. Under the new law the division of the state into districts was vested in a Board established for that purpose. Had this Board recognized the fact that by existing law the homœopaths from all parts of the state were entitled to send patients to the Middletown hospital, they might have assigned to that hospital either a small local district from which to receive county patients, so as not to interfere with the reception of homœopathic patients from all parts of the state; or have assigned to the Middletown State Homœopathic Hospital the entire state as a district for homœopathic patients of all classes, both poor and rich. Either of these methods would have avoided the difficulty which now presents itself. The management has petitioned the Board having the matter in charge to relieve the Middletown hospital by giving it a smaller district, but thus far without success. However, whatever may be the solution of the question, a just solution will never be reached until the Middletown State Homœopathic Hospital is restored to its original status as a hospital for the adherents of homœopathy throught the entire state.

In the last annual report of that institution, the trustees of the Middletown hospital, through their president, gave utterance to a principle which may now be repeated with added force, since the truths there stated have become more evident by the experience of another year.*

"We submit, also, the principle that the Middletown State Homœopathic Hospital was originally intended and now exists for the benefit and accommodation of homœopathists throughout the commonwealth; and that such of the insane as are adherents of this method of medical practice should have preference over all others in gaining admission to this institution. Here is involved that liberty of choice and action in medical matters which is an inalienable right—a right which stands side by side with the right of liberty of conscience, or the right of civil and political liberty. We ask that the Legislature

*Twenty-first Annual Report of the Middletown State Homœopathic Hospital.

secure to homœopathists this right, beyond a question or peradventure, by the enactment of an appropriate statute. This statute should provide that all officials having authority to commit insane persons shall send them to the Middletown State Homœopathic Hospital whenever Homœopathic treatment is desired; and the authorities of this hospital should have the right to admit patients of the homœopathic faith in preference to all others."

The foregoing was written about October 1st, 1892, and represented the situation as it existed at that time. Since that time the Board for the establishment of Insane Asylum Districts had reduced the Middletown district by the removal of the counties of Suffolk, Queens and Richmond, to take effect January 1st, 1893. It is hoped that this will so far remove the stress of pressure at Middletown as to permit of the reception of patients from other parts of the state who desire homœopathic treatment.

An amendment to the law is now needed, by which public cases who desire homœopathic treatment may be transported from any part of the state to the Middletown hospital at public expense. This, if obtained, will remove what now seems to be an unjust discrimination against homœopathists, and, we hope, will result in the restoration of just rights to those who have for some time past been deprived of them.

REPORT

OF THE

Committee on Medical Legislation. Presented October 4, 1892.

The Committee on Medical Legislation conducted a very active canvass during the winter and spring of 1892.

During that canvass the Committee endeavored, by means of various circulars and appeals, to communicate information regarding the status of medical bills before the Legislature, and to invoke the active co-operation of the homœopathic medical profession.

There were *five* medical bills presented to the Legislature during the session of 1892, all of which failed of becoming laws, *four* being opposed, and *one* the Middletown bill, being advocated and approved by the Committee.

Two of these the first and second were so far reaching in their provisions, purposes and principles, as to engross nearly the whole time, careful attention and active efforts of the Committee during the entire session of the Legislature.

These bills arranged in the order of presentation are the following:

I. The Medical Students' Bill.

II. The Middletown Bill.

III. The Bayard Homœopathic College Bill.

IV. The Correspondence Bill.

V. The Superintendents' Bill.

During this canvass, lasting less than two months, there were distributed by the committee on medical legislation of the State Medical Society (old school) six thousand five hundred copies, of the following circulars, appeals and petitions, and more than *twenty-one thousand* copies by the committee on medical legislation of the State Homœopathic Medical Society.

The expenses of this canvass were met by generous contributions promptly forwarded to the committee from the following sources:

Dr. E. H. Wolcott	$ 41 00
Oneida County Homœopathic Medical Society	18 00
Kings County Homœopathic Medical Society	75 00
Dr. N. G. Richmond	1 00
Dr. M. O. Terry	2 00
	$137 00

All of which is respectfully submitted.

George E. Gorham.
H. M. Paine.
A. S. Couch.
J. M. Schley.
M. O. Terry.
J. M. Lee.
J. W. Sheldon.
N. Robinson.
F. Park Lewis.

Committee on Medical Legislation.

CHAPTER I.

The Medical Students' Bill.*

Members of the Committee on Medical Legislation were informed early in the session of the Legislature of 1892, that a determined effort would be made by medical students attending the several medical colleges in the State of New York, to secure the passage of a bill providing for the exemption of the entire class of 1893, from the provisions of the state licensing law, chapter 507, laws of 1890.

It was asserted that nearly *all* the medical students in all the medical colleges in the state, about one thousand in number, were active participators in this movement, the claim having been made, that if the class of 1893, could secure exemption, succeeding classes could, following the precedent thereby established, more easily obtain like exemption. It was alleged that the students had effected a thorough organization; had entered systematically upon the canvass; that committees thereof, in some localities, had begun their work even prior to the fall election; and that by *personal* interviews with the members elect of the legislature, much *sympathy* had been awakened in their favor, and many *pledges* of support had been obtained.

As a result of this thorough preparation, early in January the so-called medical students' bill (Senate 145, Assembly 513), was introduced into both houses.

The Work of the Committee against the Bill.

The committee on medical legislation, however, failing to give full credit to the strength of the organization, and failing to realize that *personal* effort, intense *earnestness* and *concerted* effort on the part of the students, even in an unworthy cause, would acquire controlling force, suddenly awoke to the fact that the bill had actually passed the Senate, and that there existed on the part of the members of the Assembly a large measure of *sympathy* for the students and a strong desire to support their bill.

*An act to amend chapter five hundred and seven of the laws of eigteen hundred and ninety entitled, "An act to establish boards of medical examiners of the State of New York for the examination and licensing of practitioners of medicine and surgery; to further regulate the practice of medicine and surgery, as amended by chapter three hundred and eleven of the laws of eighteen hundred and ninety-one."

"SECTION 1. Section eleven of chapter five hundred and seven of the laws of eighteen hundred and ninety, is hereby amended so as to read as follows:

§ 11. This act shall not apply to any student who duly matriculated in a legally incorporated medical college of the State of New York before the *first day of December*, eighteen hundred and ninety, provided that such student within three months after the exactment of this amendment shall file with the secretary of the board of regents of the university of the State of New York a certificate setting forth the fact of such matriculation, verified by the applicant, and signed by the secretary of the faculty of the college in which he matriculated.

"§ 2. This act shall take effect immediately."

This state of affairs aroused the committee into immediate antagonistic action, the result thereof being indicated by the preparation and distribution throughout the state of the circulars, letters and appeals herewith appended.

As a result of this canvas begun on February 17th, the bill was amended March 23d on its second reading in the Assembly by substituting the words "fourth day of June" for "first day of December," thereby confining the application of the bill to *those students only* who actually matriculated prior to the enactment of the licensing law of 1890.

The bill was defeated notwithstanding very persistent personal effort put forth in its behalf, mainly by the students themselves.

The students succeeded, by misrepresentation, in awakening a large degree of interest and *sympathy*; quite sufficient, it is confidently believed, to have secured its passage had not numerously signed and most earnest protests thereto been repeatedly presented by almost the entire medical profession of the whole state.

The canvass for and against this measure awakened more of interest and personal effort on the part of the parties engaged therein than any since the enactment of the licensing law of 1890.

The defeat of the bill clearly indicates that the members of the medical profession of all schools are earnestly endeavoring to maintain the system of state medical licensure represented and established by the act of 1890, creating State Boards of medical examiners; and that they are unequivocally antagonistic to any legislation that will lower or in any way impair the standards of medical acquirements established thereunder.

Arguments Advanced by the Students in behalf of their Bill

From the Buffalo Courier, February 23, 1892.

The medical students of Buffalo University, class of 1893, say

"We yield to none in our admiration of the principles of the law of 1890, but we object to unjust discrimination which would exempt from examination men of the class of 1893 merely because of a few days' difference in the date of matriculation. Those who matriculated on June 4th, 1890, when the law was passed, would not have to undergo examination, while those matriculating on June 5th, 1890, would be examined although the exempted and the unexempted attended the same lectures and took precisely the same course.

"It is not the principle but the inconsistent application of it to which we object; therefore we think it would have been fairer to have exempted the entire class of 1893, and not merely a fraction of it."

Acting-chairman A. T. Lytle of the medical class of 1893 of the Buffalo University said yesterday: "We are not opposed to the principles of the law of 1890 but to its inequitable application whereby an unjust discrimination is made against all students matriculating after June 5th, 1890 and to be graduated in 1893. Among the 60 students of our 1893 class probably 25 matriculated prior to June 5 and as regards the other 35, an invidious distinction is made. Mind you, we don't question the benefits of state examinations at all, but we think students who take in the same lectures, the same classes—precisely the same course—ought to be on a footing of perfect equality. For my own part I may say that I am exempt from the state examiners any way, having matriculated in April, 1890, still I can see the inconsistency of the application of the new law which will operate against probably two-thirds of the graduates of 1890 throughout the state.

"The word matriculate, as you are aware, means simply the enrolling of the student on the books of the college. What justice is there in saying because a man's name was enrolled a day ahead of another that one of these should undergo a State Board's examination and the other not? Our position is clearly set forth in the petition sent by us to the Legislature.

"It bore the signature of more than forty members of the class of 1893 of the Buffalo University. The other twenty members of that class did not sign as they were not affected by the laws of 1890."

Petition Presented by the Students to the Legislature.

To the Speaker and Members of Assembly:

"We, the undersigned, students of medicine in the Medical Department of the University of Buffalo, would pray of your Honorable Body the favorable consideration and passage of the amendment hereunto appended.

"We began the study of medicine under the laws of the State of New York prior to the passage of the late examination medical license law (Chapter 507, Laws of 1890) in full good faith with the then existing law.

"The late amendment to this said medical license law has relieved from the requirements therein mentioned all those matriculating in a legally incorporated medical college prior to June 5, 1890.

"This very act has divided the senior classes in the medical colleges throughout the State of New York, a part of each class having matriculated during the spring session prior to June 5, 1890, which session is an acknowledged preliminary one neither recognized nor contemplated in the courses for graduation, while the rest of the class matriculated at the regular session of the same year.

"We are all members of the same class, pursuing the same studies, required to pass the same college examinations, and will graduate at the same time as those of our classmates who happened to matriculate a few weeks earlier, and yet by virtue of said amendment (Chapter 311, Laws of 1891) a part of this class are allowed to practice in this state, a privilege not permitted under the present law to the other members of equal attainments in the medical profession.

"While we heartily commend the wisdom of the original law, we can but feel that your Honorable Body would not knowingly divide our class by exempting a part from its requirements without extending the same immunities to all.

"Therefore we again ask that the privileges bestowed upon a part of the class may be granted to all by the passage of the amendment hereunto appended:

Copies of Circulars and Appeals Issued in opposition to the Bill.

CIRCULAR NUMBER 1.*

Four thousand five hundred copies were distributed to members of the medical profession (old school) throughout the state. February 17, 1892. Fifteen hundred copies were also distributed together with an equal number of circulars 2 and 3, by the committee on Medical Legislation of the State Homœopathic Medical Society.

DEAR DOCTOR:—A bill has just passed the Senate (and is more than likely to pass the Assembly unless earnest and immediate efforts are made by the members of our profession to defeat the same) which if it becomes a law, will practically nullify until September 1, 1894, the excellent medical law of 1890.

"Such an unfortunate state of affairs would be a crying outrage, as it would indicate a step backward in the fight for medical education and public welfare which it might take years to recover.

"The bill in question has a very innocent appearance; it is however in fact an effort, which has once before succeeded, to exempt all medical students from the provisions of the medical law of 1890, who matriculated *prior to December 1, 1890.* Those students who matriculated at a medical college subsequently to June 4, 1890 (the time of the passage of the original law) knew that the law of the State required that they should pass an examination before a State Board of Medical Examiners, no matter where they may have graduated, and this proposed law, if passed, will exempt almost one thousand medical students from the provisions of Chapter 507 of the Laws of 1890, and hence is a species of special and selfish legislation of the most pernicious kind.

"There is no valid argument in favor of this bill; still through personal solicitation and selfish appeals it has already passed the Senate, and it is in a fair way to reach the Governor.

"The law governing the practice of medicine in the State of New York is being approved and adopted in all parts of the country. It is said, by educators, to be one of the fairest and best laws on the statute books of any government in the world. Almost daily requests for copies of this law are received from all quarters of the globe; and its praises have been sounded in congratulatory letters to its projectors by physicians and laymen from far and near.

"Should such an excellent law, passed after more than twenty years of struggle in legislative halls, be emasculated year after year because of the lethargy of our professional brethren, when those selfishly interested are so energetic and persistent? The answer rests with you and all of us.

"If you desire to crush out this early cry on the part of the students against high medical standards; if you desire to preserve intact the excellent law which it is now sought to amend and practically nullify, write or telegraph your Member of Assembly and Governor R. P. Flower at once (delay is now dangerous), that the entire medical profession, not only of the state but of the country, regardless of creed or school, is opposed to Assembly Bill 513; that it is special and selfish legislation calculated to benefit the few to the detriment of the many, and that it should not prevail. If you value a higher standard in the profession of medicine; if you believe in adding to its dignity and worth, you will not put this letter aside until you have lent your aid towards the defeat of this proposed legislation."

*By the committee on Medical Legislation of the State Medical Society, Drs. D. B. St John Roosa, Daniel Lewis and Maurice J. Lewi.

CIRCULAR NUMBER 2.

Fifteen hundred copies of circular 2 and 3, together with as many of number 1, were distributed February 17th to homœopathic physicians throughout the state.

DEAR DOCTOR:

"The committee on medical legislation find that concerted action has been taken by medical students about to graduate, for the purpose of securing such legislation as will procure their exemption from the provisions of the law requiring an examination by the State Board of Medical Examiners.

"The students' bill, (Senate 145. Assembly 513), much to our surprise, passed the Senate yesterday (Feb. 16), Senators having been misled by false and one-sided argument.

"Members of the legislature are led to believe that this bill, if enacted, will apply *only* to those who matriculated before the enactment of the present licensing law; whereas the bill has been intentionally changed so as to include in its scope whole classes of students who *began* the study of medicine and matriculated *since the enactment* of the present law.

"To release these students, therefore, who entered upon medical studies in full view of the salutary and elevating provisions of the licensing law, would be a retrograde movement for the justification of which no good or sufficient reasons can be adduced.

"The following resolutions were unanimously adopted at the recent meeting of the State Homœopathic Medical Society:

"*Resolved*, That we deprecate and will actively oppose any legislation instituted for the purpose of rendering the principles of the medical educational laws of this state inapplicable to medical students about to become members of the medical profession of this state, who matriculated at a medical college *since the enactment of the present licensing laws.*

"*Resolved*, That the committee on medical legislation be authorized to endeavor to secure the amendment to Assembly bill 513, so as to make its provisions applicable to such students *only* as shall furnish the Regents evidence of having entered upon the study of medicine and matriculated *prior to the enactment of the present licensing laws.*

"The committee most heartily approve the sentiments ably and forcibly set forth in the inclosed circulars, and they add their urgent solicitations in behalf of earnest, united and immediate effort on the part of the whole body of the medical profession of all schools, in a sturdy and persistent defence of the salutary provisions of our licensing laws, which are universally approved and are being rapidly adopted by the medical profession in other states and countries.

"We sincerely hope that you will *at once* endeavor to render all the aid in your power, by calling personally if practicable on your Member, at his home residence on Saturday; by *writing* to him and to Gov. R. P. Flower *at once*, and by inducing other influential persons to write to them; and by every proper method oppose the further progress of this bill, the provisions of which are alike derogatory to the standing and ability of the medical profession and prejudicial to public interests.

"The local members of the committee request that they may be furnished the names of Members of Assembly who have *promised to vote against* the students' bill.

CIRCULAR NUMBER 3.*

Two thousand copies of circular number 3, together with copies of numbers 1 and 2, were distributed February 17th, to homœopathic physicians throughout the state.

*By the Committee on Medical Legislation of the three State Boards of Medical Examiners, Drs. W. C. Wey, H. M. Paine, A. S. Couch, H. J. Linn, M. J. Lewi and E. S. Moore.

DEAR DOCTOR:

The State Board of Medical Examiners invokes your influence with your Member of Assembly in opposition to the passage of Assembly bill 513, which exempts medical students, who matriculated after the law of 1890 took effect, from the operation of such law, in respect to examination for license following graduation.

Reflecting the sentiment of the profession on this subject, we refer to the recent action of the Medical Society of the State of New York, on February 3rd, and the resolutions adopted by the State Homœopathic Medical society on February 10th, protesting against any attempt to change the provisions of the statute, under which the work of the State Board of Medical Examiners is satisfactorily progressing.

"Both the welfare of the public and the dignity and high standing of the medical profession, require that the provisions of the present law should be faithfully applied; this effort therefore, prompted by selfish motives on the part of those who will live to reap the benefits derivable from this improved equitable and unifying system of medical licensure, is to be sincerely deprecated and vigorously opposed.

"The bill, greatly to our surprise, passed the Senate yesterday, Senators having been misled by false and one-sided argument. It is necessary therefore, that every Member of the Assembly and Gov. R. P. Flower, should be *immediately informed*, by hundreds of letters from the profession and other influential persons, regarding the harmful tendencies growing out of a precedent such as the passage of this bill will surely establish.

CIRCULAR NUMBER 4.

One hundred and fifty copies of this circular, in the form of a manuscript letter, were mailed, February 20th, by Dr. H. M. Paine, to homœopathic physicians residing in eighteen of the eastern, and northern counties of this state.

DEAR DOCTOR:

"We find that some of the students now in the medical colleges have formed an organization for the purpose of defeating the examining and licensing law of 1890, by securing an exemption therefrom.

"The law of last year exempted those who entered upon the study of medicine *prior* to the enactment of the licensing law; the bill of this year, if enacted, will exempt those who began *since* the law took effect, a procedure that is wholly subversive of the principle of establishing and maintaining uniform and impartial standards of medical scholarship, for the accomplishment of which the present licensing law is eminently fitted.

"The students, through their representatives, have besieged the legislature, beginning their work, in some places, immediately after election; and by shrewdly stating their argument have, we find, awakened far more of *interest* and *sympathy* than we supposed possible.

"In order that the members of the legislature may hear opposing arguments; arguments in support of the principles of sound medical learning, it is necessary that the medical profession of all schools should *immediately earnestly* and *unanimously* protest against the passage of any bill designed to lower the standards of medical learning, or in any way interfere with the operations of the present admirably constructed, eminently practical, and thoroughly effective licensing law.

"Let the profession flood their representatives in the legislature and the Governor with hundreds and thousands of letters protesting in the most emphatic and unequivocal terms *against* the passage of the medical students' bill.

"Let resolutions strongly opposing the bill be adopted at meetings of local medical

clubs and of county medical societies, and let these be published in local papers, and when published, let marked copies be mailed *at once* to representatives in the legislature.

"The committee will be glad to obtain a list of names of all members of the legislature who may have promised to oppose the students' bill; also a copy of all resolutions or editorials relating to this subject."

CIRCULAR NUMBER 5.

One thousand copies of this circular, together with as many of circular number 6, were distributed February 27th.

DEAR DOCTOR:

"The nearly successful attempt, on the part of medical students, to secure, for sinister purposes *only*, exemption from the provisions of the licensing law, will be promptly thwarted by decided expressions of popular disapproval, as soon as the attention of the public can be directed to its partisan and one-sided character.

"There is not the slightest question but that the reasonable and effective checks and safeguards established under the licensing law are essential, in order to adequately protect public interests; and if sustained and enforced by popular approval, will greatly contribute to the dignity and high-standing of the medical profession.

"In order to assist in disseminating information, and in directing attention to this important subject, copies of the inclosed articles, or others of similar import, should be published as extensively as possible; and suitable condemnatory resolutions should be adopted and published wherever practicable.

"The committee desire to be informed regarding the progress of the work, copies of any resolutions adopted or editorials published, and particularly the names of Members of the Legislature who may express a willingness to oppose the students' bill."

CIRCULAR NUMBER 6.

This circular, a synopsis of a paper read at a special meeting of the Albany County Homœopathic Medical Society, by Dr. H. M. Paine, was published in the *Albany Press* and *Knickerbocker*, in the *Albany Evening Journal*, and in the *Albany Morning Express*, of February 22d, 1892.

One thousand copies, issued in the form of a reprint, together with as many copies of circular 5, were distributed, February 27th.

"At a special meeting of the Albany County Homœopathic Medical Society held Saturday evening for the purpose of taking action antagonistic to the passage of the so-called medical students' bill, the discussion thereon elicited unanimous expressions of disapproval. The trend of the remarks may be summarized as follows:

"*First.—The injustice of the measure.* The bill of last year, exempting students who furnished evidence of having begun the study of medicine *prior* to the passage of the bill, embodied an element of fairness; this bill, however, in exempting whole classes of students who entered upon their medical studies *since* the enactment of the present licensing law, represents no considerations of fairness, equity or expediency.

"The present licensing law, that of 1890, has received the unanimous approval of the whole body of the medical profession of this state, the wisest and ablest representatives of all schools harmoniously uniting in rendering the principles of this admirably constructed law practically and thoroughly effective.

"No reasonable person will have the hardihood to assume that when these very students shall have become wiser by experiencing the benificent and conservative provisions of the licensing law, they will not look back on their present misguided and ill advised efforts with unmingled sorrow and regret.

"*Second.—Its Inexpediency.* It is to be considered that the medical students of to-day will naturally endeavor to enter upon practice as easily and as quickly as in former years; they should consider, however, that the new and additional tests of scholarship, inaugurated by the licensing law of 1890, have been introduced because, and *only* because the higher and more nearly uniform standards of medical learning, thereby established, are considered reasonable and absolutely essential, in order to conserve and promote public interests, by securing adequate protection from the dangers of ignorance and misguided empiricism.

"They should consider also that these new and added tests are no higher and no more severe than those required of all well-educated medical students in all foreign countries.

"How much better, more noble, and worthy of commendation it would be, therefore, for those who are about to assume the responsible duties of well-qualified practitioners to accept, without question, such tests of proficiency as are established by law, and such as are universally recognized by the great body of the medical profession as necessary prerequisites?

"This attempt on the part of medical students to enter upon practice without complying with the requirements of the licensing law, if successful, will not only prove discreditable to themselves, but will antagonize and hinder the development of an improved and completed system, the principles of which are being gradually approved and adopted by nearly all the other States of this union.

"For these and other cogent reasons it is very desirable that the students' bill (Senate 145, Assembly 513), should be opposed by all who hold the promotion of public welfare above selfish and sinister purposes and interests.

"In accordance with the forgoing opinions the following resolutions were unanimously adopted:

"WHEREAS, Senate bill 145, and Assembly bill 513, is designed to exempt medical students who have begun the study of medicine *since* the enactment of the present licensing law, from its elevating and salutory provisions; and

"WHEREAS, The authors of this bill, being prompted by selfish and ulterior motives *only*, in order to defeat, as far as may be applicable to themselves, the operations of a law, the faithful and impartial administration of which will greatly promote public interests, by securing well-qualified and thoroughly competent practitioners of medicine; and

"WHEREAS, The sinister and short-sighted motives of the promoters of the students' bill are strikingly made manifest by the fact, that they themselves will live to reap the benefits derivable from the operations of the present admirably constructed, eminently practical, and thoroughly effective licensing law, and

"WHEREAS, Efforts put forth with a view of lowering or interfering with approved and well established standards of medical learning, formulated and applied under the provisions of the licensing law of 1890, are unquestionably to be considered alike subversive of public interests, and derogatory to the standing, dignity and usefulness of the medical profession; hence should be deprecated, and should meet with decided expressions of disapproval and the most active opposition; therefore,

"*Resolved*, That the members of this society hereby pledge themselves to exert every proper means in their power for arresting the progress and preventing the passage of the so-called medical students' bill,

"*Resolved*, That a committee be appointed to give practical effect to the spirit and purposes of the foregoing declaration."

CIRCULAR NUMBER 7*.

One thousand copies of this circular, together with as many copies of the petition (circular 8) were distributed February 22d to four or five physicians in affiliation with the State Medical Society in each of the villages and smaller cities throughout the state.

"DEAR DOCTOR:—We find that in order to successfully antagonize the medical students' bill an organized effort must be put forth for obtaining *evidence* showing that the sentiment of the entire body of the medical profession throughout the state is in direct and positive antagonism to the passage of this pernicious measure.

"To obtain and make such evidence as effective as possible we have herewith furnished copies of a form of a petition.

"We desire that the petition be signed by physicians residing in your immediate locality, in duplicate, each physician signing *two* copies, one to be used in the Assembly; the other to be presented if necessary to the Governor.

"Obtain as many signatures, *of physicians only*, as can be secured during the next *two or three days* and return them at once to the office of the secretary of this committee at number 71 Lancaster street, Albany, N. Y.

"Also at the same time give us an *estimate* gathered from conversation and otherwise of the *probable number* of physicians in your assembly district or in the entire county who are opposed to the provisions of the medical students' bill.

"The committee desires to obtain copies of all resolutions adopted by county medical societies, and also copies of any articles or editorials that may have been published in newspapers circulating in your locality."

CIRCULAR NUMBER 8.

One thousand copies of this circular, embracing a protest and petition, were distributed February 22d, together with as many copies of circular 7.

Five thousand five hundred copies of this circular were distributed March 5th, together with two thousand copies of circular 9, two of the former with one of the latter to each physician.

Petition against the Medical Students' Bill.

From physicians residing in *County.*

HON.

We, the undersigned, physicians residing in your Assembly district, protest against the passage of Assembly bill 513 (Senate 145), as establishing a precedent that will be alike antagonistic to the public welfare and derogatory to the principles of sound medical learning, and we earnestly request you to cast your vote and exert your influence against the passage of the same

Name.	Residence.

*By the committee on medical legislation of the State Medical Society.

CIRCULAR NUMBER 9.

Two thousand copies of this circular, together with five thousand five hundred copies of circular 8, were distributed March 5th.

"DEAR DOCTOR :—We learn that, in all probability, the medical students' bill will, in a few days, be reported *for consideration* in the Assembly, and that it will come up for its second reading within a few days thereafter, at which time its defeat can be accomplished *only* in case at least *sixty-five negative votes* are secured.

"Hence it is of the utmost importance that every member of the medical profession should *at once* endeavor to exert his influence in the most positive manner in behalf of higher medical educational interests, by calling personally on their Members when at their home residences on Saturday, and by repeatedly writing to them strong personal letters.

"It will indeed become a surprise to many, if through supineness on the part of the profession, this bill, prompted only by selfish and ignoble purposes, should become a law.

"In order to successfully antagonize the medical students' bill a systematic and well-organized effort must be put forth for obtaining an expression of the sentiments of the *entire body of the medical profession* throughout the state. Such evidence, showing a unanimous, direct and positive opposition to the passage of this pernicious measure, will have very great weight; and, if made *immediately manifest*, will, doubtless, prove effective.

"To obtain and make such *evidence* as effective as possible, we have herewith furnished copies of a form of a *petition*.

"Every physician who receives a copy of this appeal, and of the accompanying petitions, is earnestly solicited to affix his own signature thereto, and also secure the names of as many of his associates (physicians only) as can be readily obtained, these to be signed *in duplicate*, each physician signing *two* petitions.

"When signed, one petition is to be *at once* mailed to the Member of Assembly from the district represented, together with a personal letter, urging the importance and necessity for opposing the students' bill.

"The other petition to be mailed to Dr. H. M. Paine, 105 State street, or Dr. M. J. Lewi, 71 Lancaster street, Albany, N. Y., to be used, if need be, in case the bill should reach the Governor."

"Also, at the same time, give us an *estimate*, gathered from conversation and otherwise, of the *probable number* of physicians in your Assembly district, or in the entire county, who are *opposed* to the provisions of the medical students' bill.

"The committee desires to obtain copies of all resolutions adopted by County Medical Societies, and also copies of any articles or editorials that may have been published in newspapers circulating in your locality."

CIRCULAR NUMBER 10.

This circular, prepared for immediate issue in case the students' bill had passed to its third reading unamended, shows in clear and forcible statements, the reasons advanced by the students in support of their bill, and the answers and arguments in opposition thereto.

This elaborately prepared statement would have been promptly printed and distributed throughout the state, had not the Assembly defeated the bill by amending it, so as to make its provisions conform to the amendment approved in 1891.

"The committee find that through persistent *personal* effort the medical students' bill has been reported to the Assembly, thereby giving it a place on the calendar.

"The bill will soon come up in its order for its *second* reading, and for final passage (third reading) a few days thereafter.

"During this interval of a few days, probably less than two weeks, those of the medical profession throughout the state, who have not yet expressed opposition to this unwise and harmful measure, should *loose no time* in making known their disapproval thereof in the most positive terms.

"The text of the act of last year, (Chapter 311, Laws of 1891) and that of this year (Senate 145, Assembly 513) are precisely similar in construction, except that in the bill of this year the words '*first day of December*' are substituted for the 'fifth day of June.'

The reasons advanced by the students in favor of amending the licensing law of 1890 a second time, by which its action will be postponed six months later than seems wise or necessary, are the following:

FIRST. That the act of last year fails to exempt many students who really began the study of medicine prior to the enactment of the law of 1890, as numbers of them did not matriculate until fall, although, as they claim, they actually entered upon the study of medicine in the spring of that year.

The answer to this proposition, in substance, is as follows:

First. The members of the medical profession have no desire to interpose any unnecessary barriers to the admission of all properly qualified applicants.

Second. The act of 1890, by its own construction was purposely made inapplicable for nearly a year and a half after its passage, in order that the classes of 1890 and 1891 might be excused from its provisions.

Third. The amendment of last year exempting those who were able to furnish reasonable evidence, (as indicated by the fact of matriculation) of having entered upon the study of medicine *prior to the enactment of the law*, was then considered and accepted as a final concession to the wishes of the students, and a *compromise* to be held as a fair, reasonable and equitable adjustment of the points at issue, and one that is still so regarded except by those students who hold their own selfish interests above those of public welfare.

Fourth. That as the passage of the licensing act of 1890 was preceded for five or six years by an exhaustive canvass, participated in by nearly every member of the medical profession in the entire state, it is *not* creditable to the intelligence of the medical students of that year to claim that they were *ignorant* of the provisions of the licensing law; nor reasonable to assume that they did *not* expect to comply with the requirements thereof. The fact is, every one of them entered upon the study of medicine in the *full expectation* of complying with its reasonable, necessary and salutary provisions.

Fifth. That inasmuch as the students of 1890, 1891 and 1892 are already exempted from the action of the licensing law, the members of the profession are unanimously of the opinion that, in behalf of public interests, *no further* concessions should be made, and *no injustice* will be done by requiring *all* the matriculants of the last half of the year 1890 to comply with the provisions of the law.

Sixth. That the passage of the students' bill, exempting those who matriculated *subsequently to the enactment* of the licensing law, will establish a precedent contrary to good order; inimical to public interests; and one that in future whole classes, prompted by like selfish motives, will surely endeavor to make use of, and will thereby weaken and finally annul the safeguards established by the admirable, equitable and liberal provisions of the licensing law of 1890; a procedure alike derogatory to the cause of higher medical education and prejudicial to public interests.

SECOND. The students further claim, in support of their bill, while it may be proper and necessary to require graduates of medical colleges *out* of the state to obtain a license

from a State licensing board, it is an act of injustice to require the graduates of New York State medical colleges to obtain a *second* license.

The answer to this claim may be briefly stated in the following propositions:

First. That the state cannot have *two* standards of medical educational acquirements, one for graduates from out of the State, the *license*; and another for graduates from New York State colleges, the *diploma*.

Second. The question as to whether the state *license* or the college *diploma* should be made the legally recognized standard, after long and exhaustive discussion, participated in for several years by the entire medical profession of this state, was most emphatically settled in favor of the *state license*, by the enactment of the licensing law of 1890.

Third. The real reason why the *state license* has been substituted for the *diploma*, is found in the fact, that after an hundred years of trial, the latter is unsatisfactory and unreliable, in that it represents a standard fixed by *interested private corporations* (medical colleges), hence is never uniform, and is often outrageously defective, being many times plainly granted for sinister and improper purposes.

Yet, in plain view of these facts these simple-minded, unwise and inexperienced students, for selfish purposes, are seeking to perpetuate a system that they themselves will in time acknowledge to be degrading and harmful in its tendencies.

Fourth. Liberty to enter upon practice being a *privilege* and not a *civil right*, the State has the right to establish any educational tests that it may deem essential and advisable, and it has chosen the *license*, as in every way preferable to the *diploma*, and has with marked unanimity, impartiality and justness made it applicable to *all graduates alike*, whether from medical colleges located in or out of this state.

Fifth. This provision of the New York State law is generally approved by the medical profession, sixteen or seventeen other States having recently adopted laws providing that *all* persons desiring to enter upon practice therein must first procure a license or certificate from state examining boards, no exception being made in favor of their own graduates.

Sixth. This argument disingenuously brought forward by the students, is misleading in that it involves a question *not at* issue; it is one, however, that when presented *personally* by the students themselves appeals directly to the *sympathies* of the Members, and will impel them to favor the bill, on the theory of helping the weaker party, unless its unsoundness and inappropriateness are promptly explained and condemned.

THIRD. The students also claim that their limited means will not enable them to pay a license fee of $25.00.

The answers to this proposition are mainly:

First. That if this argument has any force it will apply equally to *all* future candidates; hence is irrelevant, lest it be construed into a direct assault upon the sound, conservative and equitable provisions of the licensing law itself.

Second. That the fee is no larger than is really necessary in order to meet contingent and actual expenses.

Third. That there are no large salaries to be paid the examiners or any one else.

Fourth. That while in all probability, at a future time, a sufficient amount to provide for the payment of the necessary expenses will be annually put in the supply bill, as this cannot be done at present, there is no alternative.

Fifth. It is to be considered that the student, on receiving a license, gets a *full equivalent* for all his expenditures of time and money, the state license, once secured, being recognized as evidence of educational qualifications that will admit him to practice, without further examination, in any state in this country; and one that ranks equally with the standards approved by European examining and licensing boards.

Sixth. That the sum is no larger than is required, under similar laws in other states, and is ten dollars less than the amount of the fee provided under the law of 1872.

Seventh. That the amount of the fee charged can in no way be regarded as a barrier or evidence of an organized *combination* on the part of medical men for keeping out those who rightfully and properly ought to be admitted to the profession.

The students' bill is not demanded in the interests of good order; it is unsupported by popular or professional approval, in fact it is put forward in opposition to the welfare and repeatedly expressed wishes of both; the students themselves are not unanimously in its favor, many of them having refused to give it their approval; it is *purely* and simply a glaring specimen of pernicious *class* legislation, uncalled for by any existing public necessities; it is alike derogatory to the standing, dignity and recognized ability of the medical profession, and is antagonistic to public interests; its enactment will constitute an unwelcomed and harmful precedent, the influence of which will be degrading, in that it savors of *laxness* as to recognized standards of medical learning; it is supported *only* by, relatively, a small number of medical students, who instead of gladly accepting such *reasonable tests* as are universally approved, as necessary and reliable are endeavoring, by means of this bill, for purely selfish and *sinister* purposes, to lower well recognized standards of excellence, and to set aside such wise and necessary safeguards against fraud and favoritism, as are provided by the salutary and eminently conservative provisions of the licensing law of 1890.

Plainly the students' bill has no backing. It stands alone, condemned by all who hold, public interests above personal considerations; without merit; without a following; without support or approval except from a few candidates for medical honors who, to save a little trouble and expense are unwilling to comply with reasonable and universally approved tests of medical attainment.

It would seem, that when the really harmful provisions of such a partisan bill are pointed out to the Members of Assembly their opposition thereto would be at once secured; but such is not the fact.

The bill, if passed, will be approved, not because of intrinsic merit, but because, and *only because* the students have succeeded by *personal effort* constantly applied.

They are and have been, ever since the bill was introduced, in daily attendance on the floor of the Assembly. And by means of those constant *personal* efforts they have succeeded in awakening an interest in their cause, and in gaining the *sympathy* of large numbers of the Members.

By means of their misleading and false arguments systematically, persistently and *personally* applied by themselves or their representatives, there is still real danger that this pernicious bill will be approved.

Inasmuch as the students are succeeding, or are likely to, by *personal* efforts alone, not by merit or the justness of their claim, the profession must, with equal assiduity, put forth *personal* efforts in opposition to the bill. They must make their wishes and demands known in the most *positive and emphatic terms.* And as the Members of Assembly are to be found at their home residences from Friday evening to Monday morning of each week, at least one more opportunity will be afforded the profession for presenting their reasons for opposing the bill, and for personally urging their own Members to give it their unqualified disapproval.

It is hoped that this, the *last appeal* to the profession, will draw out such unanimous and vigorous protests as to show an overwhelming sentiment of disapproval on the part of the medical profession of this state.

These evidences of opposition should show that the grounds thereof are prompted *only* by a sincere desire to secure the promotion of public welfare, and in the interests of higher and uniform standards of medical education, and *not in any manner* to impose a hardship or an injustice upon a few misguided medical students, who are striving to enter the profession without complying with reasonable tests designed to furnish satisfactory evidence of their qualifications therefor.

That the sentiments of the entire medical profession throughout the state are positively antagonistic to the enactment of any amendments to the licensing law of 1890, there are evidences the most abundant and convincing.

Resolutions emphatically expressing such disapproval have been unanimously adopted by nearly all the local and county medical societies in this state.

Large numbers of leaders and editorials have been published in the most influential papers in nearly all of the counties in this state, these articles showing with forceful meaning the tend of public sentiment against any measure, the tendency of which will lower recognized standards of medical learning, or permit the exercise of professional rights and responsibilities except after compliance with approved tests of scholarship.

Large numbers of letters expressing disapproval of the provisions of the students' bill have been written by physicians residing in every county in this state.

Numerous petitions, have been mailed to the Members of Assembly imploring them to oppose the passage of the bill. These have been signed by large numbers of physicians residing in all the larger cities and towns of this state, and in numbers of instances these petitions have received the signatures of *every reputable member* of the medical profession residing therein.

The extended correspondence conducted by the committee on medical legislation shows conclusively, that the prevailing sentiment of the whole profession is unmistakably and unequivocally opposed to the provisions of the students' bill.

The committee have asked correspondents to give an *estimate* of the relative proportion of members of the profession in their respective localities who oppose the passage of the bill, and the replies thereto have uniformly expressed the belief, that the active and influential members of the profession were unanimous in their hostility thereto.

CIRCULAR NUMBER 11.

This circular comprised a complete list of the Members of Assembly, their business occupation and home addresses. It was issued in order to facilitate correspondence, on the part of the profession with members of the legislature. Fifteen hundred copies were printed.

Extracts from Newspapers Showing Antagonism to the Provisions of the Bill.

The following leaders, editorials and reports, selected from many others of similar import, were published in daily papers and medical journals. These articles unmistakably indicate the trend of public sentiment in antagonism to the removal of accepted educational standards of medical acquirements, and the removal of even temporary nullification of recognized safeguards and tests of scholarship such as are provided by the present medical laws of this state.

The selected articles are arranged chronologically. In large numbers of instances marked copies were mailed to the members of the legislature from the districts represented.

(*From the Utica Morning Herald, February 20, 1892.*)

A Special Meeting of the Oneida County Homœopathic Medical Society.

At a special meeting of the Oneida County Homœopathic Medical Society, held February 19, 1892, action was taken in opposition to the attempt to annul the present medical licensing law designed to raise the standards of medical education.

This attempt has taken the form of a new bill, which is now before the legislature, and is designed to render that law inapplicable to medical students who matriculated during the year 1890.

This medical students' bill is looked upon with disfavor by leading medical men of all schools, as tending to the lowering and nullification of the high medical educational standards which the State has recently been able to establish.

The society fully indorsed the sentiments set forth in circular number 1, and also adopted the resolution approved at the annual meeting of the State Homœopathic Medical Society, held February 10th, 1892.

(*From the Buffalo Courier, February 21, 1892.*)

Students Protest. The Class of 1893 Does Not Seek Exemption.

The members of the class of 1893, of Niagara University, are fully in accord with the sentiments expressed by the faculty of that institution, that the intent of the law passed by the State Legislature of 1890, establishing a State Board of Medical Examiners, ought *not* to be disturbed by amendments year after year exempting classes from examinations before these boards.

At a meeting of the class held February 20, 1892, at the college building, resolutions were adopted, embodying the views of the members, to be presented to the Representatives in the Legislature from Erie County.

The resolutions are given under the heading "Resolutions."

(*From the Buffalo Express, February 21, 1892.*)

Doctors and Students Object. They Want No Exemption from the Law Requiring State Examinations.

The Erie County Medical Society met last evening to take formal action in opposition to an objectionable bill (Assembly 513), now pending in the legislature.

This bill provides for amending the law recently passed establishing a State Board of Medical Examiners, and providing for the issuing of licenses to medical students who have matriculated in the medical colleges prior to December 1, 1890.

This would postpone the actual operation of the law for a year. There has been already one postponement, and last evening many arguments were advanced against further delay in the matter.

(*From the Practitioner's Monthly, March, 1892.*)

"The Baby Student's Relief Bill

is what the *New York Medical Journal* very pertinently dubs Assembly bill number 513, which in plain English means, that all medical students who entered upon their college courses after the new medical law went into effect, but during the same year, shall be exempt from the requirement of passing the state examination.

"The committee on legislation of the Medical Society of the State of New York, has

issued a circular, dated February 17th, urging physicians throughout the state to personally request members of the Assembly to vote against the bill.

"Great pressure is being brought to bear by the friends of the measure, and it is to be hoped that every physician in the state will use his influence to assist in defeating this proposed measure.

"All that the profession asks for itself is, not to be deprived of the means of keeping itself clean.

(*From the Albany Evening Journal, February 22d, 1892.*)

A High Standard in Medicine.

The indignation with which the medical profession throughout the state, including all the recognized schools of medicine—old school, homœopathic and electic—scouts at the idea of the radical change in the law, disguised in the form of a very innocent-looking bill, which has already through the petitions and beseechings of interested students, "kissed" its way through the Senate, is evidence of the deep interest which attaches to the excellent qualities of the medical law of 1890, which was placed on the statute books after a twenty years struggle with quacks and charlatans.

The conditions existing at the present time whereby students who matriculated at a medical college subsequent to the passage of the law and with a full knowledge of its provisions, seek to be exempted from its exactions, are in keeping with the yearly exemption bills passed by our legislature to make things easy for the law students after state restrictive measures have been adopted, which on their face guaranteed the graduation of competent lawyers only.

The lawyers, finally realizing how their earnest efforts for the advancement of their profession were being turned into ridicule because of the yearly nullification of the law by enactments of exemption, finally made a vigorous fight against this special legislation, and since that time the standard of acquirements for a diploma in law has been steadily advancing.

The doctors throughout the state, profiting from the experience of their legal brethren have taken the bull by the horns and are making a vigorous and united fight against Senate bill number 145 and Assembly bill number 513.

The public is interested only to the extent of demanding from its representatives in the legislature that no backward step be taken in this matter; that the high standard established in medicine be maintained under all circumstances, and that in keeping with this principle, which in effect guarantees the licensing of competent and educated physicians only, no single student be exempted from the provisions of the law which existed when he or she first matriculated at a medical college for the purpose of legally commencing the study of medicine.

(*From the Albany Morning Express, February 22, 1892.*)

A Pretty Contest.

The attention of the public has been attracted to a very pretty quarrel which is now engaging the attention of our State Legislature. There are unusual features in the controversy, one of the most pronounced of which is found in the fact that for once, at least, in their existence, the doctors are united.

On June 4th, 1890, after knocking at the legislative halls of the state for more than twenty years, the physicians succeeded in having placed on the statute books a law which was to have become operative September 1st, 1891, whose purpose was to divorce the teaching from the licensing power as far as medicine and its practice was concerned.

The college faculties, and in fact all physicians of all schools in the state, agreed, in view of the lax manner in which colleges, both without and some within the state, were utilizing their powers for making doctors regardless of qualifications of the practitioner and the feelings of an outraged public, that on and after September 1st, 1891, no person could enter upon the practice of medicine and surgery in the State of New York, no matter where he may have received his degree, without first passing an examination before a State Board of Medical Examiners, of which there had been appointed in accordance with the provisions of this act, one to represent each of the recognized schools of medicine in the state, viz.: the old school, the homœopathic and the eclectic.

The law was pronounced by educators the land over as a mighty stride in the direction of higher medical education, and passed both branches of the legislature unanimously.

But war came in the form of a petition to the legislature of 1891 on the part of the students who matriculated in some medical college of the state previous to the passage of the law. The young men framed a bill which, although strenuously opposed by the medical society of the State of New York, became a law, and exempts from the provisions of the medical law of 1890 all such as had matriculated at a medical college in the state previous to the passage of that law.

There seemed some injustice in passing this measure, for it is not usual for legislative bodies to pass enactments that shall be retroactive and there was merit in the claim that a man who legally (that is by matriculation) began the study of medicine previous to the passage of the law should be exempted from its exactions other than those which existed when he began in good faith his part of the contract of which the college was the second part. Emboldened by the success of their fellow students of one year ago, the class which is to graduate in the spring of 1893 had a bill introduced in the Senate a short time ago exempting them likewise from the examinations of the State Board of Medical Examiners.

Well, the boys got out and hustled and in hot haste the bill was passed by the Senate and is now somewhere in the Assembly; but in the mean time the profession of the state, old schools, homœopaths and eclectics, ten thousand strong, having become informed of the danger which threatened their deeply cherished idol, have taken up arms, and it looks to a disinterested outsider as though no more exemptions would be granted by the Legislature of the State of New York.

It is natural that a sympathy should exist for the student who is struggling to make ends meet in the endeavor to receive his license to practice medicine, but it is not clear to us why men who matriculated at a medical college after the passage of a law, which, having for its object the ennobling of the profession exacted certain conditions from all who desired to practice the noble calling of medicine, should in any way be accorded an exemption from the law under which they began the legal study of their profession.

The only claim made by those who are urging the change in the law, which seems to have any merit is, the one least dwelt upon by them, namely, that the State should pay the twenty-five dollar fee instead of the applicant; but if the State refuse to make the appropriation in a bill especially drawn for such a purpose, let there be no change in the law, no honest student fitted to practice medicine should be afraid of passing a fair examination as to his qualifications, and the people of the State of New York are entitled to the protection which this law guarantees, viz., a future class of competent physicians, no matter what schism in medicine they may represent. Assembly bill number 513 should not pass.

(*From the Albany Argus, February 22, 1892.*)

The public generally is inclined to hold the dominant party responsible for the acts of its legislative bodies, even though measures without the realm of politics are as fre-

quently subjects for legislative action as those having a political bearing, and it behooves the Democratic majority in the legislature to move cautiously in all matters pertaining to the public weal.

This is even more markedly true of educational affairs, and as at the present time there is a bill pending in the legislature, having for its object the radical change, for a time being at least, of the very excellent medical law of 1890, and as, moreover, the entire medical profession, without regard to "pathy" is opposed to the exemption of any more students from the licensing examination of the State Boards of Medical Examiners. it is well to move cautiously before running counter to the wishes of the ten thousand or more practitioners of medicine in the state who are making vigorous opposition to any of the changes contemplated by the amendment to the law known a Senate bill 145 and Assembly bill 513.

There is one phase of this situation which affects the people's rights and the public welfare, and it finds expression among physicians as well as laymen in this statement: Future generations of physicians should be scientific and competent men, no matter how serious the students consider the tests which are applied.

(*From the Buffalo Evening News, February 22, 1892.*)

Snide Doctors, Erie County Physicians Want Them Kept Out of Practice, The Legislature Will Hear from Erie County in no Uncertain Way, a Bad Bill Jumped On.

The doctors of Buffalo are up in arms over an attempt to nullify the powers of the State Board of Medical Examiners for a year longer, thus leaving a loophole for the entrance of more incompetents into the profession.

A large meeting of the Erie County Medical Society was held last night to protest against the passage of the bill now pending in the legislature.

The Medical Society bombarded the objectional bill at all points with a variety of weapons, with a resolution, a memorial, a letter ordered sent to all the medical societies in the state arousing them to action, and finished up by appointing a committee to go to Albany and personally speak and work against it.

The feeling was very strong, amounting to indignation and if Senator O'Connor, author of the obnoxious measure, had been present, he would hardly have escaped violence.

One prominent physician, addressing the society, said: Let us kill this bill once and forever. Let us send it back to hell, where it came from,

The bill passed the Senate and is now in the custody of the Assembly committee on Public Health.

By the way, Dr. Goldburg, who is an assemblyman was present.

The bill if passed would exempt one more class of medical students from undergoing the rigors of a state examination. The Doctors look upon it as in the interests of "Snide" medical colleges.

They say if this bill passes exempting a class another will be brought forward next year, and lo, the law concerning state examinations will never become operative.

President William W. Potter called the meeting to order and explained the provisions of the bill.

On motion Drs. Cary, Lathrop and Storck were appointed a committee to draft resolutions expressive of the sentiments of the society. They returned with the following resolutions, which were adopted:

WHEREAS, The Medical Society of the County of Erie is and has been from the earliest agitation of the subject in favor of a separate state Examining and Licensing Board; and,

WHEREAS, This society took the initial action which led to the passage of the present law (Chapter 507 Laws of 1890) on the subject; and,

WHEREAS, This society has heretofore, namely, on the 20th of March, 1891, expressed its opposition to any amendments of the law until it should be thoroughly tested; and,

WHEREAS, This society has heard that a bill for the exemption of students who have matriculated in medical colleges prior to December 1st, 1890, has already passed the Senate; and,

WHEREAS, This society has also learned that the same or a similar bill is now pending in the Assembly, known as Assembly bill, Number 513 and,

WHEREAS, This society deems the passage of and such measure as directly prejudicial to the public interests of the state in that it delays an attempt to improve the public health service by giving to the people better educated and more amply equipped physicians; and

WHEREAS, The faculties of the University of Buffalo and the Niagara Uuniversity the only medical teaching faculties of Western New York, are members of this society, and as such members in their individual capacity, as well as in their official relations to their respective medical colleges. are absolutely and unqualifiedly opposed to any amendments at present to the law in question; therefore,

Resolved, That we, the members of the Medical Society of the County of Erie in special session assembled, do hereby request the Senator and Members of the Assembly from this Erie county district to use all honorable means to defeat any legislation which may have been presented or which may hereafter be offered in either house of the legislature, looking toward any change or modification in Chapter 507 of the Laws of 1890 as it now stands, and particularly do we request each and every one of our representatives in the State Legislature of 1892 to use their utmost endeavors to prevent the passage of the bill referred to, now understood to be resting with the Committee on Public Health in the Assembly and known as the Assembly bill Number 513.

CHAS. CARY,
THOS. LOTHROP,
E. STORCK,
Committee.

Dr. Hopkins then read the following:

To the Assembly:

The Medical Society of the County of Erie, in special session convened, on this 20th day of February, 1892, respectfully and humbly petitions your honorable body to reject Assembly bill 513, which provides certain amendments to Chapter 507 of the Laws of 1890, such rejection being asked for the following reasons:

FIRST. Because the law referred to (Chapter 507 Laws of 1890) is a beneficent measure, framed and enacted in the interest of the public, to promote public health, and to prevent unqualified men from exercising the functions of physicians.

SECOND. Because it is a wise law, one in accordance with the spirit of the age, is in keeping with similar statutes prevailing in other states on the subject of separate license for physicians, and has been used as a model in many of the states. We are informed that some twenty-four states now provide that physicians shall not practice within their borders without a state license.

THIRD. Because the law was passed after considerate and prolonged discussion and argument, not only among medical men but by the public in general and through the newspaper press in particular, and it did not take effect until some 15 months after it received the sanction of the executive. (It was signed June 5th, 1890, to go into operation September 1st, 1891)

FOURTH. Because already such students as have matriculated in the medical colleges in this state prior to June 5th, 1890, have been exempted from the provisions of the law by a special act which amended it to that effect last year.

FIFTH. Because we feel that it is prejudicial to the public welfare, in opposition to the spirit of the law, and against right, justice and good government to grant any further exemption, or to amend the existing statute in any particular until it has been tested by at least a year's trial in its application to the graduates of colleges in the State of New York.

SIXTH. At present only those physicians who have received diplomas granted from without the borders of the State of New York are amenable to the provisions of the law, and we believe it unjust to compel the citizens of our state to undergo state examinations that are not also required of the citizens of the State of New York. Discriminations of this sort against citizens of other states has always been considered contrary to the spirit of our fundamental laws, and certainly was not the intent of the framers of the existing law on the subject of state examinations for state licenses.

SEVENTH. For these and other reasons which might be named almost ad infinitum, but which we forbear to enumerate lest we needlessly take up too much of your valuable time, we pray you in all humility to grant our petition.

Dated at Buffalo, February 20, 1892.

For the Medical Society of the County of Erie.

[Signed]

WILLIAM WARREN POTTER,
President.

Attest:—ELI H. LONG,
Secretary.

The hearing before the committee will probably take place next Wednesday, and the society adopted a resolution to have a committee of three go to Albany and do personal work against the bill.

The committee will consist of President Potter, Dr. Edward Clark and Dr. Lothrop.

The society also approved of a circular letter which will be sent to all the county medical societies, urging their co-operation in defeating the bill.

(*From the Buffalo Courier, February 22, 1892.*)

Indignant Faculties. Rumors of a Corruption Fund Raised by Medical Students.

The bill that has lately passed the Senate and is now in the hands of the Assembly Committee on Public Health, and which provides for exempting the medical students in colleges of this state of the class of '93 from examinations by the State Examining Boards, as provided for in the laws of 1890, is being most strenuously opposed by the reputable physicians of the state.

There will be a hearing before the committee in Albany, probably next Wednesday, when the doctors will make themselves heard in a way that cannot be mistaken.

The Medical Society of the State of New York, the strongest body of physicians in the state, through a committee of which, Dr. D. B. St. John Roosa, an eloquent speaker and able physician, is chairman, has addressed the following circular to thousands of physicians in the state:

Dr. William W. Potter, president of the Medical Society of the County of Erie, said last night:

It is understood the students of the class of '93, of which there are 900 or 1,000 in the state, have employed a professional lobbyist to work for the bill exempting them from examination by the state boards.

The bill passed last year exempting all who matriculated before June 5, 1890, the day the bill establishing the state examinations became a law. The present obnoxious bill proposes to exempt all who matriculated previous to December 1, 1890. This would exempt another entire class, or the students of one entire year, as the schools hold through the winter and the matriculations all, or nearly all, occur in the autumn months.

"We have understood that some of the members of Assembly of Erie County had taken the ground that they had heard no expression concerning the bill from the doctors of Erie

County; but there was a meeting of the Medical Society of the County of Erie last night when a decided expression was recorded that may serve to guide our conscientious representatives as to the wishes of these gentlemen.

Dr. Henry R. Hopkins of number 433 Franklin street, one of the faculty of the University of Buffalo, was asked last night if the students of the class of '93 of that school had contributed to a fund for the passage of the exemption or nullification bill. He said:

"I do not know. I have heard that some of them have done so. I have understood, in fact, it is stated in some of the medical journals, that every student in the state in the class of '93 has been assessed $5 towards a corruption fund, which is to be placed at the disposition of the honorable senator from New York who introduced the iniquitous exemption bill; that in case he succeeds in securing the passage of the measure he is to have $5,000. If he does not succeed he is to have $1,500. I am told the students of the Niagara University were approached for contribution to this fund and that they declined to contribute."

"Are all the members of the faculty of the University of Buffalo opposed to the proposed law?"

"Yes, they are all opposed to it. They look upon it as a direct insult to the medical schools of this state. It is a measure of high tariff protection, so to speak, on the assumed ignorance of the medical students of this state, that whereas the students of Philadelphia, Boston, or Chicago schools are judged to be entirely competent to stand an impartial state examination, the graduates of the New York City, Albany, Buffalo and Syracuse schools are not sufficiently taught to be able to stand such an examination, and the aid of the state in special legislation is sought for to shield their incompetency. Self-respecting teachers in medical schools necessarily are not very fond of such damaging charges of incompetence, as it involves a reflection upon the tutors as well as the students.

"There is a supposition in the minds of medical men generally that important legislation affecting the medical profession might properly be first submitted to some of our state societies. These societies all held their annual meeting within the present month in the city of Albany. This bill was not submitted to them or any of them. It is not recommended by any general or local medical society. As far as I know it is deemed by medical men generally to be directly inimical to the best interests of the public health."

The faculty of the Buffalo University, as is well known, has taken positive ground in favor of a state examination from the first. They also expressed themselves very emphatically against the law of last year exempting the class of '92. They memorialized the Governor, urging him to withhold his signature from the bill.

Some people may think the law providing state examining boards is a matter of taste, of theory or of caprice, that there is nothing practical in it. Such people have no conception of the importance of the subject. Over twenty states have set up the state examination. If plumbers, engineers, hack drivers, pedlers, and almost all kinds of skilled laborers have to be licensed, how much more important that the qualifications of the medical men whose position in society is 1,000 times more important than any of those because it involves the life or death of his patrons, be fully passed upon and proven? and why should not the state in her own interest, inquire into such a man's fitness to do the work he professes to be able to do. That is what the state examination means.

To illustrate how important a matter public health is, it is only necessary to understand that one-third of the productive energy of a so-called healty community is wasted by the destructive presence each year of preventable disease.

A high standard of public health can never be maintained until the country commands the service of the medical profession, every member of which is thoroughly competent for the duties of his art. A single disease costs the productive energy of this country every year more than the governments of Russia, Great Britain, Germany, France and Italy spend for the maintenance of their navies.

(From the Rochester Herald, February 23, 1892.)

It Should be Defeated.

The physicians of this state are agitated over the discovery that a body of medical students who are about to graduate have succeeded in getting through the Senate of this state a bill which will exempt them from the provisions of the law requiring an examination by the State Board of Medical Examiners. For years the qualified medical fraternity of New York of the several schools labored to secure legislation that would protect the public from incompetent practitioners.

At last a law was enacted; but under the bill noticed above about a thousand new physicians would soon be turned loose to practice without submitting themselves to the examination the law now wisely prescribes.

The Assembly should put its foot on this new measure.

A medical student who is afraid of a fair examination and tries to secure the repeal of the law requiring it, practically confesses that he is not qualified to enter the profession he proposes to enter.

From the Buffalo Daily Courier, February 23, 1892.

The attempt to amend the State Medical Board law is an attempt to lower the standard of medical education in the interest of a few aspirants for a medical degree who evidently distrust their own ability to pass a thorough examination.

Such a proceeding is against the general welfare and the legislature should give it no countenance.

The interest of the people demands that the highest possible standard of medical education be rigorously maintained.

From the Rochester Democrat, February 23, 1892.

The students of medical colleges in this state ask exemption from the examination by the State Board of Examiners. An exemption bill has passed the Senate, and both schools of medicine have risen up against the further progress of the measure. The theory of the students is that the completion of the prescribed course is sufficient and the theory of the practicing physicians is that the course must be supplemented by an outside examination. The present legislature has done some queer things and no one can tell what it will finally do in the matter of this bill. The present law exempts those who entered medical colleges before the law for outside examinations was passed, and it is held to be improper for those who matriculated after the exemption law was passed to ask for exemption.

From the Rochester Post Express, February 23, 1892.

Defeat It.

A recent organization has been formed by some of the students now in the medical colleges for the purpose of defeating the examining and licensing law of 1890, by securing an exemption therefrom. The law of that year exempted those who entered upon the study of medicine prior to the enactment of the licensing law; the bill of this year, however, if enacted will exempt those who began since the law took effect, a proceeding that is wholly subversive of the principle of establishing and maintaining uniform and impartial standards of medical scholarship for the accomplishment of which the present licensing law is eminently fitted.

The students, through their representatives, have besieged the legislature, beginning their work in some places immediately after election.

The Assembly will do itself credit and the public a great service by defeating this bill which would exempt at least 1,000 students from an examination before the State Board of Medical Examiners.

II. The Middletown Bill.*

The history of medical legislation relating to the homœopathic care and treatment of the insane in New York State is briefly summarized in the following statement.

The Middletown Homœopathic Hospital was incorporated and set apart for the homœopathic care and treatment of the insane in 1870.

For twenty years thereafter the representatives of the homœopathic school, and the friends of that system of medicine, residing in any part of the state were able to avail themselves of the benefit of homœopathic treatment for patients for whom such treatment was desired.

In 1890 a law was enacted providing for the appointment of a State Commission in Lunacy, consisting of three persons, one physician, one lawyer and one layman; and providing also for giving the commission almost complete *control* of the management of the insane throughout the entire state.

---

*"An act to amend section eight, title seven, chapter four hundred and forty-six of the laws of eighteen hundred and seventy-four, entitled "An act to revise and consolidate the statutes of the state, relating to the care and custody of the insane; the management of the asylum for their treatment and safe keeping and the duties of the State Commission in Lunacy."

SECTION 1. Section eight, title seven, chapter four hundred and forty-six of the laws of eighteen hundred and seventy-four, entitled "An act to revise and consolidate the statute relating to the care and custody of the insane; the management of the asylums for their treatment and safe-keeping; and the duties of the state commission in lunacy," is hereby amended to read as follows:

§ 8. The charges to be made by the trustees of the Middletown state homœopathic hospital for the care and treatment of pauper and indigent patients shall be uniform with the rates for board and maintenance in the other state hospitals. County judges and superintendents of the poor in any of the counties of this state, and all county and state officers having authority to commit insane persons to any of the state hospitals for the insane, may, at the request of relatives, friends or guardians of any such insane person, either public or private, for whom homœopathic treatment may be desired, commit without further legal requirements, such recently insane persons to the said Middletown state homœopathic hospital; and the trustees of the said Middletown state homœopathic hospital shall have the right to receive into said hospital private insane patients from any of the counties of the state for whom homœopathic treatment may be desired by their relatives, friends or guardians, upon such rates as shall be fixed by said trustees in each case.

§ 2. This act shall take effect immediately.

Among other powers given the commission, that of arranging hospital districts was provided for; each hospital to have a district of its own, and the commitments to such hospital to be limited to its own district.

The commission being wholly non-homœopathic in its predelictions, had no regard for the *special rights*, acquired by the charter of the Middletown hospital, by which homœopathists throughout the entire state were permitted to avail themselves of homœopathic treatment at their own homœopathic hospital.

The disastrous results of this system were soon made apparent, by the crowding into that hospital of large numbers (more than four hundred) of non-homœopathic cases to the *exclusion* of large numbers of cases for whom homœopathic care and treatment was *specially* desired, legally provided for, and for twenty years had been uninterruptedly maintained.

This anomalous condition confronted the homœopathic medical profession at the beginning of the session of the legislature of 1892.

They found themselves nominally in the possession of a large, flourishing and successfully managed homœopathic institution; yet practically as completely without the ability to avail themselves satisfactorily of its advantages as if it had never existed.

How to extricate themselves and the representatives of the homœopathic system therefrom, and to restore to the managers of the Middletown hospital their original charter rights and privileges, became at once, a perplexing problem, the practical solution of which required the exercise of wise and prudent deliberation and action.

The committee on medical legislation, on entering upon the work, found that the Revision Commission, appointed for the purpose of revising and codifying *all* the laws of the state, had prepared and were about to submit to the legislature, a revised code known as "The Lunacy Law."

The committee accordingly made very frequent and urgent appeals to the Revision Commission, with a view of securing such changes of form as would enable the homœopathists of the state to commit all homœopathic cases to the Middletown homœopathic hospital.

These proposed changes took the following forms:

First. That of a *special law* providing for the re-enactment of portions of the original charter, which were supposed to have been impaired by the lunacy laws of 1890, by which the management at Middletown would be able to receive and provide preferably for homœopathic cases, both pay and public, and to admit non-homœopathic cases *only* when the accommodations therein would permit.

Second. The insertion of a clause in the Revision bill providing for the appointment of a homœopathic representative in the State Commission in Lunacy; or

Third. Such changes of the proposed Revision bill as would provide for the establishment of a *separate* State Homœopathic Commission, such commission to have entire charge of homœopathic interests, as far as these relate to the care and management of the insane for whom homœopathic care and treatment may be desired; more particularly the establishment, as far as may be practicable, at desirable localities throughout the state of *several state homœopathic hospitals.*

At repeated hearings before the Revision Commission, the superintendent and managers of the Middletown hospital, and also the superintendents and managers of several other state hospitals, most earnestly protested against the provisions of the proposed "revision bill," whereby the *control* of each state hospital would be *taken from* its own local board of managers, and *given to* the State Commission in Lunacy.

These repeated protests and the arguments adduced, soon convinced the Revision Commission that there existed among the managers of the hospitals for the insane, wide-spread antagonism to the proposed *centralization* of irresponsible power and control in the State Commission in Lunacy.

On that account the Revision Commission wisely decided to postpone the presentation of their proposed "revision bill" for one year, for the purpose more particulary, of enabling the managers of the several state institutions to agree among themselves as to what changes are required in order to promote an effective, uniform and economical management throughout the entire state.

The failure of this bill was not ascribable to lack of interest in that institution. The bill passed the Senate almost unanimously, there being only one dissenting vote.

Prior to the day the vote was taken in the Assembly there were no indications that the bill would be defeated. Its failure was brought about solely by adroit management so skillfully arranged as to prevent an expression for or against the bill on the part of the members.

The defeat was secured by loading the bill with an amendment, the provisions of which placed the trustees and superintendent entirely under the *control* of the State Commission in Lunacy.

For eighteen years, under the Middletown hospital charter, patients from any part of the state for whom homœopathic treatment was desired, were uniformly committed thereto. This *right*, however, has been practically abrogated by the insanity law of 1890, under which

eight hospital districts are established, the Middletown district being so large (seven counties) as to keep that institution *filled* to overflowing with non-homœopathic cases, to the constant *exclusion* of homœopathic patients.

The action of the present districting system, therefore, whether intentional or not, is that of practically debarring the citizens residing in fifty-three counties from exercising the *civil right* to avail themselves of the advantages of homœopathic treatment in their own homœopathic hospital.

This, the Middletown bill, was so constructed as to enable the trustees to continue to receive, as heretofore, from any part of the state, those patients, both *pay* and public, for whom homœopathic treatment is desired *first*, and then when there were vacancies, to admit non-homœopathic cases from the Middletown district.

It is to be noted also that under existing laws the State Commission in Lunacy has ample power to reduce the Middletown district so as thereby to prevent surplussage of non-homœopathic cases in the homœopathic hospital.

The fact that such change is *not* made, clearly indicates that the commissioner has no desire to recognize the *civil rights* of the homœopathists of this state; in fact, the commissioners have repeatedly stated that the Middletown hospital must *not* in any manner be made an exceptional institution; and that the regulations governing the commitment of patients from its district (seven counties) must be similar in every respect with the orders and regulations governing all the other state hospitals for their districts.

It will be seen at once, therefore, that the only resource left the homœopathists of this state is that of changing the organic law so as to *restore to the Middletown hospital* its original charter rights and privileges.

The Middletown bill provided, moreover, for the reception of both *pay* and indigent cases.

It is proper for the homœopathic profession throughout the state to recognize the fact that the success of the Middletown hospital is fairly attributable to the large proportion of *pay* patients that have, prior to 1890, from every part of the state voluntarily availed themselves of its superior advantages, the revenue derivable therefrom being sufficient to enable the management to furnish a larger number of better paid and more useful attendants, and better care, better food and clothing; factors which contributed materially to the comfort and welfare of the patients, and provided also more speedy and a larger percentage of recoveries than could otherwise have been obtained.

Hence it is a well-established fact, that the larger the revenue derived from *pay* patients, the better will be the condition, care and treatment of the poor patients therein, and the greater will the likelihood of recovery.

This is true not only of Middletown, but also of all other hospitals for the insane.

It may be fairly assumed inferentially, therefore, that opposition to state care *pay* patients, springs *only* from sectional jealousy and misguided partisanship, and *not* from a desire to provide suitably for *all* classes of the citizens of the state, both poor and rich alike.

Wise economy, prudent management and ingenuous philanthropy, founded on correct sociological principles, point unmistakably to the establishment of *state care for both classes* of the unfortunate insane.

Copies of Circulars and Appeals Issued in Behalf of the Middletown Bill.

CIRCULAR NUMBER 12.

An appeal to the homœopathic profession in behalf of the Middletown bill (Senator Richards', Senate 306). Twelve hundred copies were issued April 8, 1892.

DEAR DOCTOR:

The Committe on Medical Legislation desires to call your special attention to, and solicits your *prompt assistance* in support of, the Middletown Hospital bill (Mr. Richardson's Senate bill 306).

The provisions of this bill will restore to this institution its charter privileges, regarding the admission of homœopathic cases to the homœopathic hospital, and will restore to the friends of the homœopathic system, the *right* to secure the commitment, from *any part of the State, of those for whom homœopathic treatment is desired.*

We earnestly hope, therefore, as there are only *ten more legislative days*, that you will *at once* communicate, by letter or telegram, with your Members of Assembly, and ask their favorable action in behalf of the Middletown Hospital bill.

Duplicate copies of a circular letter are herewith inclosed. These are furnished in order to save you the time and trouble of writing a personal letter explanatory of the reasons for supporting the bill.

The name of one of the Assemblymen is to be entered on each; your own signature is to be appended, and then forwarded, as *promptly as possible*, one to each of the Members of Assembly from your county, together with a short statement to the effect that you *heartily indorse the sentiments therein set forth, and express the hope that he will approve and vote for the bill.*

The letters should be addressed to the Members, at the Capitol, at Albany, N. Y.

CIRCULAR NUMBER 13.

A summary of the reasons for approving the Middletown bill (Senator Richardson's, Senate 306), so constructed as to constitute an appeal from physicians to the Members of Assembly.

Designed for distribution *first* to physicians, and when signed and addressed by them, to be remailed to their respective members of the legislature.

Two thousand four hundred copies were printed, in order to provide each homœopathic physician with *two* copies, there being two or more members of assembly from nearly all the counties in the state.

DEAR SIR:—Under the present lunacy law (Chap. 126, Laws of 1890), *seven* counties are designated the Middletown Hospital district, from which district the institution is filled to overflowing with patients for whom homœopathic treatment is *not* desired or expected; more than four hundred non-homœopathic cases being in the hospital at the present time.

These non-homœopathic cases are continually *excluding* large numbers of homœopathic patients from all parts of the state, for whom such treatment is desired, and for whom the hospital was originally designed, and for eighteen years has been prudently, economically and satisfactorily maintained.

In order to enable its trustees to go on with its beneficent work, in the future as in the past, that of providing homœopathic treatment for those patients for whom it may be desired, both pay and public, a bill was introduced into the last legislature, which bill failed on account of the Senate dead-lock.

The same bill, simply amending the Middletown Hospital charter, by re-enacting its original provisions, so far as these relate to the admission of homœopathic cases, has been again introduced into the legislature, and has passed the Senate by a vote of twenty-one to one.

The passage of this bill constitutes a matter of simple justice. We do not ask for special or undue favors. We demand nothing other than our *rights* as loyal citizens.

The provisions of the bill will not in any manner interfere with any public measure. By means of it the Trustees will be able to provide homœopathic treatment for homœopathic cases.

The further effect will be, if it is found that there is insufficient room for non-homœopathic cases, that the State Commission in Lunacy will be required to reduce the size of the Middletown district from *seven* to *two* or *three* counties, a procedure which the present lunacy law provides for and one that is alike required in the interests of humanity, and in the interests of the homœopathic medical profession in every part of the state.

Hoping that you will give this bill your unqualified approval and active support, and thereby protect the *rights* of the members of the homœopathic school to be provided with *room* for homœopathic cases at their homœopathic hospital, we remain,

Yours,

III. The Bayard Homœopathic Medical College Bill.*

The provisions of this bill were completely at variance with those of existing statutes, and were wholly antagonistic to the pronounced sentiments of almost the entire medical profession of this state.

The enactment of this bill would have restored to the *degree* its licensing powers, which degree could be conferred by a *pri-*

*"An Act to Incorporate The Bayard Homœopathic College Hospital and Dispensary."

SECTION 1. John Cochrane, W. K. Lathrop, L. Laflin Kellog, Henry Stanton, Mary Mildred Sullivan, George H. Sullivan, Luther Kountze, Annie P. Kountze, Rudolph F. Rabe, Sidell Tilghman, William Utz, Cornelia W. Carle, Louisa Van Vliet, Elizabeth Kendell Upham, F. Cazenove Jones, Henrietta Lamar Jones, William C. Egleston, Louise E. C. Furniss Margaret Stanton Lawrence, Thomas F. Clark, Elizabeth Cady Stanton, Walter D. Starr, Franklin Miller, Grace Livingston Furniss, Eliza O'Reilly, F. O'Reilly and Lewis Sanders, Ella C. Eggleston and Benjamin Lord, and their successors and associates, as hereinafter provided are hereby constituted and a body corporeat and politic by the name of The Bayard Homœopathic College, Hospital and Dispensary, and by that name may and shall have succession and shall be in law capable of suing and being sued, pleading and being impleaded, defending and being defended in all courts and places whatsoever, in all manner of actions, suits, matters, complaints and causes, and may have and use a common seal and change and alter the same, and shall be capable of purchasing and taking by gift, grant, devise or bequest, in trust or perpetuity, and of holding real and personal estate, and property for the uses and purposes of the said corporation; to provide, conduct and maintain in said city of New York, by means of voluntary contributions and otherwise, a medical college and a hospital and dispensary for the poor and others who shall be desirous of receiving homœopathic treatment in medicine and surgery; with all the suitable buildings, departments and appliances for said college, hospital and dispensary; in which hospital, medical and clinical instruction may be given to students and others, matriculants and attendants in said college and hospital. The property of said corporation, both real and personal, shall be exempt from taxation and assessment so long as the same is used exclusively for the charitable purposes of said corporation. The trustees may fill all vacancies in their own number. They shall appoint a faculty to consist of not less than six persons qualified to instruct students in all subjects pertaining to the practice of medicine and surgery; to examine and recommend candidates for the degree of doctor of medicine. The trustees of said corporation shall organize said hospital into such departments, make such by-laws and prescribe such rules and regulations for the government and management of the same in connection with said college as from time to time shall be lawful, necessary and proper; and all patients in said hospital shall be under the professional care of physicians and surgeons skilled in and practicing under the homœopathic system of medicine, who shall be appointed from time to time by and be subject to removal by the board of trustees. Six of the said trustees shall constitute a quorum for the transaction of all business except so far as the same may relate to the leasing, purchasing, holding and disposing of real estate.

§ 2. The distinctive system of therapeutics to be taught in this college and the only method of medical practice to be employed or permitted in the hospital or dispensary departments, shall be homœopathic, that is, the single remedy shall be administered only in its dynamized form and strictly in accordance with the "law of similars."

§ 3. The board of trustees are empowered, upon the recommendation of the faculty to grant and confer the degree of doctor of medicine upon students of the said college but no such student shall receive such degree unless he shall be twenty-one years of age and shall have pursued the study of medicine for at least three years under the supervision of a reputable physician, and have attended at least two full terms of instruction in an incorporated medical institution, the last of which terms shall have been held by this college and hospital. Both may be pursued together, and also the degree of doctor of homœopathic medicine upon graduates of other medical colleges who shall have attended a post graduate course at this college. The said board of trustees may also confer said degree either honorary or ad eundem in pursuance of the recommendation of the faculty upon eminent practitioners of medicine and persons holding diplomas from other reputable incorporated medical institutions. The said trustees, in testimony of the conferment of said degree, shall present to the candidate the diploma of said college and hospital, duly certifying the same and attested by the seal of the corporation and the signature of their president and secretary and *a majority of the instructors in said institution*. The said diploma shall bear the date of its conferment by the order of the board of trustees, and shall entitle persons receiving it to all the rights, privileges, immunities and liabilities of physicians as declared by the laws of this State.

§. The funds and property of said corporation shall be used and applied solely for the uses and purposes thereof. The said corporation may hold such collections of books,

vate corporation, after *two* courses of medical lectures, both of which could have been pursued at the same time. It gave the corporators the right to grant *honorary and ad eundem* degrees, a right which for good and wise reasons was abolished by the law of 1887. And its authors sought to evade the sound provisions of present laws by which the regents are authorized to charter all desirable institutions of learning, after satisfactory evidences have been furnished showing a sound financial foundation of $50,000, with which to conduct and properly maintain the work of such *corporation.*

The passage of this pernicious bill would have constituted a retrograde movement in the matter of medical scholarship, as unwise in conception and purposes as it would have been prejudicial to public interests and degrading to professional standing.

A repetition of attempts at similarly partisan legislation for similar purposes is to be expected. Such efforts must be closely watched and energetically opposed.

IV. The Correspondence Bill.†

The author of this bill claimed that numbers of persons of sound mind are committed to hospitals for the insane, and that many after entire recovery, are held in such hospitals for many months and even years by the officers thereof.

---

and of the productions of nature and of art, as may be necessary for the purposes of medical and clinical instruction; and it may mortgage, from time to time, its property, or any part thereof, by its bonds and mortgages, and may sell its property by its conveyances, and the same to be executed under the common seal of said corporation and acknowledged by the president, attested by its secretary or treasurer.

§ 5. The said corporation may establish a dispensary in connection with or separate from its other buildings.

§ 6. This corporation shall be subject to chapter eighteen, title third, part three of the revised statutes, to chapter three hundred and sixty, of the laws of eighteen hundred and sixty entitled "An act relating to wills," and to chapter five hundred and fifty-three of the laws of eighteen hundred and ninety, amending "An act to limit the amount of property to be held by the corporations organized for other than business purposes."

†An act to prohibit the opening or reading of certain letters written or received by the inmates of insane hospitals and asylums by those in charge thereof, and providing for the delivery of such letters to the insane.

SECTION 1. Each and every inmate of each and every hospital and asylum for the insane, both public and private, in the State of New York, shall have the privilege every three months of selecting one individual from the outside world with whom he or she can correspond, without censorship, at least once a week; and such chosen correspondent shall write his or her own name on the outside of every letter he or she writes to said inmate, which shall be delivered to the person to whom addressed without being opened by any person whomsoever, and it is hereby made the duty of each and every superintendent in the State of New York to furnish material for writing, inclosing, sealing,

In order to guard against the improper detention of those of sound mind this bill provided for conducting sealed correspondence with outside friends, such outside friends to be selected by the insane persons themselves.

The bill was opposed by the committee, on the ground that while, in possibly a very few rare instances, its provisions would be humanely serviceable, its good qualities were far out-balanced by the vexacious and interminable controversies sure to arise, by which large numbers of innocent and unoffending outside parties would be necessarily involved.

This bill was crowded through the legislature by means of false statements, persistently presented to the last day of the session by a committee of misguided women. The bill was subsequently *vetoed* by the governor.

V. The Superintendents' Bill.†

The enactment of this bill would have compelled the trustees of every state hospital for the insane to empower some one other than the superintendent with the general supervision of the buildings, premises and farm products connected with his institution, a provision that

stamping and mailing the letters of said inmates to said chosen correspondents, and all such letters shall be deposited by the writers thereof in a post-office box, provided for mail matter, in some place of easy access to the inmates of each and every insane hospital and asylum in the State of New York, and the post-office rights of said inmates, so far as this chosen correspondent is concerned, shall be free and unrestrained and shall be under the protection of the postal laws. And the superintendent of each and every insane hospital and asylum shall be charged with the duty of taking such letters from the post-office box and depositing them in the United States mail for delivery when the post-office department does not supply the free collecting system near or in the insane hospital or asylum where he is superintendent. But this act is not to be construed as limiting inmates of insane hospitals or asylums in regard to other correspondence under the supervision of the superintendents or managers of any hospital or asylum for the insane in the State of New York. The provisions of this act shall not apply to insane criminals.

§ 2. Any superintendent, attendant, doctor or other person refusing or neglecting to comply with, or willfully or knowingly violating any of the provisions of this act shall be guilty of a misdemeanor, and upon conviction thereof shall be punished according to law, and shall thereafter be disqualified to hold any office in the hospital.

§ 3. A printed copy of this act shall be framed and kept posted in each ward of every insane hospital and asylum, both public and private, in the State of New York.

§ 4. This act shall take effect thirty days from its passage.

†An act to confer on boards of trustees of all hospitals in New York, which are owned by the State or receive State aid, and in which the insane poor are received and held for treatment, the entire control and management thereof.

SECTION 1. That within one month after the passage of this act the entire control and management of all hospitals now existing or which may hereafter be erected or established for the care and treatment of the insane owned by the State or which received aid from the State or county shall be conferred on the boards of trustees of those institutions, three of whom shall visit the insane hospital once a week and the whole body once a month.

would be a suitable one in a few special instances; but one which, if enacted into a general law, would unquestionably hinder rather than promote the best and most economical management thereof.

It is a provision involving duties and powers the exercise of which are now left discretionary with the boards of directors of the several hospitals, and there are no good reasons for effecting any change.

This bill provides also, for both a male and female superintendent, each to have entire control over their respective departments.

This double-headed supervision, might, in some of the larger hospitals, prove advantageous; it is one, however, which, in a large proportion of cases, would materially interfere with harmonious and economical management.

It is a matter that can well be left with the managers of each institution, existing laws being amply sufficient for all such exigencies.

The bill passed the Senate, but was not reached in the Assembly.

Copy of a Circular and Appeal Issued in Opposition to Four Objectionable Medical Bills.

CIRCULAR NUMBER 14.

This circular describes briefly four exceedingly objectionable bills, and makes an earnest appeal to the profession to exert their influence, as far as may be possible, against their approval by the Legislature.

Twelve hundred copies were issued April 8, 1892.

DEAR DOCTOR:

The Committee on Medical Legislation, desiring to report all instances of attempted obnoxious medical legislation, announces that *four* objectionable bills are in position to be rushed through during the closing hours of the session, unless arrested by vigilance and care on the part of the profession.

These are:

FIRST, The so-called "medical students' bill" (Senator O'Connor's Senate bill 145).

---

§ 2. The trustees or managers of each and every hospital owned by the state or county or receiving aid from either and in which the insane are received for care and treatment shall appoint a well qualified male physician and such assistant male physician as shall be needed to have the medical care and treatment of the male insane and to have no other duties than those which pertain to them as physicians to the insane in order that they may give their entire time and skill to the restoration of the bodily and mental health of their patients.

§ 3. The board of trustees or managers of the above-named hospitals or asylums shall appoint a skillful female physician and such female medical assistants as may be needed to have the exclusive medical treatment and care of the female insane in such hospitals.

§ 4. All acts or parts of acts inconsistent herewith be and the same are hereby repealed.

It was supposed that this bill had been rendered harmless by appropriately amending the Assembly bill (513); we now find, however, that the same bill having previously passed the Senate (145), has now been reported favorably in the Assembly and must be either amended the same as bill 513, or rejected by at least sixty-five negative votes.

It is hoped, therefore, that members of the profession will again promptly and vigorously manifest their opposition to the passage of this bill.

SECOND. An act to "Incorporate the Bayard Homœopathic College Hospital and Dispensary" (Senator McClelland's Senate bill 730).

The provisions of this bill are exceedingly objectionable in that, mainly its approval would lower well-recognized standards of medical learning, by shortening the term of study to *two* years; by permitting students to attend two courses of lectures at the same time; and by constituting its graduates legal practitioners without complying with the licensing law of 1890.

This bill has been once vetoed by Governor Hill, because its authors sought, by special enactment, to secure a legal status, the general law being amply sufficient to authorize the Regents to charter such corporations on complying with reasonable requirements and a uniform system. These reasonable and uniform requirements its authors are seeking to evade.

Such legislation would be derogatory to the medical profession, harmful to the public, and a retrograde movement in the cause of medical education, that should meet with overwhelming evidences of popular disapproval.

This measure has been rushed through the Senate, without a proper hearing, and is now in the Assembly, where, if vigorously and *promptly* opposed, the further progress of this pernicious and destructive bill can be arrested.

THIRD. An act to "Confer on Boards of Trustees of all Hospitals in New York which are owned by the State or receive State aid, and which the insane poor are received and held for treatment, the entire control and management thereof" (Senator McMahon's Senate bill 337).

This bill provides that the superintendents of insane asylums or hospitals shall give their "entire time" to the treatment of the patients, thereby prohibiting them from supervising or controlling the management of the premises on which their respective institutions are located; an unnecssary and harmful restriction, which ought to be left entirely to the judgment of the trustees of each hospital.

This bill also provides for giving the female physician and the female medical assistants the "exclusive" *control* of the medical treatment and care of the female department of each hospital, an arrangement that is not called for by any exigencies existing in any hospital in the state; and one that cannot be made practically effective, it being impossible, except in a few rare instances, to conduct a hospital satisfactorily under the care of two superintendents, each having co-ordinate powers.

This bill, first reported adversely by the Senate committee on general laws, has been reconsidered, and is now committed to the committee of the whole. It will come up for consideration within a few days, and should then be opposed and defeated.

FOURTH. An act "To Prohibit the Opening or Reading of Certain letters Written or Received by the Inmates of Insane Hospitals and Asylums by those in Charge thereof, and Providing for the Delivery of the same" (Senator McMahon's Senate bill 339).

This bill provides that the inmates of hospitals for the insane "shall have the privilege, every three months, of selecting one individual from the outside world with whom he or she may correspond, without censorship, at least once a week;" a most mischievous proceeding; one that while possibly, in a few rare instances, would not be abused, would open a wide door to endless annoyances, vexatious controversy, and frequent to irreparable injury to the character and standing of innocent and unoffending parties, without compensating benefit in any way derivable therefrom.

This bill, after being reported adversely, has been restored, and is now in the Senate committee of the whole.

Its further passage should be vigorously and actively opposed.

The members of the committee residing at Albany are endeavoring to bring such influences to bear against these objectionable bills as they are able; their efforts, however, will be greatly assisted and will prove far more effective, if vigorously indorsed by the great body of the medical profession throughout the state.

Members of the profession are earnestly requested to communicate with their members of the legislature, expressing decided disapproval of the foregoing medical bills.

As there are only *ten* more legislative days, *immediate action* is essential to success.

In behalf of the Committee on Medical Legislation.

EXAMINING BOARDS.

Records of Proceedings Held in Connection With the Organization of Three Separate Examining and Licensing Boards, With a Summary of the Requisites Preliminary to an Entrance Upon Medical Practice in the State of New York, By H. D. Paine, M. D of Albany, N. Y. (Concluding Statements.)

Medical Examinations by the Regents.

In compliance with the resolution adopted at the joint meeting of the three boards, held September 1st, 1891, requiring the members within two weeks to furnish the Regents lists of sixty questions, each in his own department, such sets were prepared and forwarded prior to the expiration of the time specified, (see page 39).

These series of questions were then submitted to the Questions Committee by Secretary Dewey, at a meeting thereof, held at Albany, late in September.

The preparatory work of revising, unifying, and perfecting the questions, having been satisfactorily completed, the date of the first examination was fixed by Secretary Dewey, and the nine applicants for examination were notified thereof.

Analysis of the Work Accomplished During the First Examination Year.

During the first examination year, viz., from September 1st, 1891 to September 1st, 1892, four regular and two special examinations were held.

The records of these examinations are as follows:

Whole number of applications for license,..... 87
Number examined, approved and licensed,..... 59
Number examined and disapproved (standing below seventy-five per cent.),..... 8
Number failing to obtain an order for an examination on account of defective academical or medical qualifications or both,..... 13
Number failing to obtain an examination from other causes..... 7

Sources of Graduation.

Names of the institutions from which the *successful* candidates were graduated.

Austria, Med. Dep. of Univ. of Vienna,..... 1
Med. Dep. of University of Cracow,..... 1
Canada, Med. Dep. of Western Univ., London,..... 1
Trinity Medical College, Toronto,..... 1
Med. Dep. of the McGill Univ., Montreal,..... 1
Med. Dep. of Victoria University, Toronto,..... 3
Med. Dep. of Victoria University, Coburg,..... 2
Med. Dep. of Laval University, Montreal,..... 1
England, Med. Dep. of University of Cambridge,..... 1
France, Med. Dep. of University of Bordeaux,..... 1
Germany, Med. Dep. of University of Heidelburg,..... 2
Med. Dep. of University of Leipzig,..... 1
Med. Dep. of University of Jena,..... 2
Italy, Med. Dep. of University of Naples,..... 1
Russia, Imperial Military Med. Academy at St. Petersburg,..... 1
Scotland, Med. Dep. of University of Edinburg,..... 1
Syria, Med. Dep. of Syrian Protestant College, Beyrout,..... 1
United States.
Connecticut, Med. Dep. of Yale University,..... 1
Maine, Bowdoin Medical College,..... 1
Maryland, Col. of Physicians and Surgeons, Baltimore,..... 1
Massachusetts, Boston University School of Medicine,..... 1
Med. Dep. of Harvard University,..... 1
Michigan, Detroit College of Medicine,..... 1
New Hampshire, Med. Dep. of Dartmouth University, Hanover,..... 1
New Jersey, Col. of Physicians and Surgeons of New Jersey,..... 1
New York State, Albany Medical College,..... 1
Long Island Med. Col. and Hospital, Brooklyn,..... 1
Med. Dep. of University of Buffalo,..... 2
New York City, Bellevue Hospital Medical College,..... 2
Med. Dep. of University of the City of New York,..... 2
Medical College and Hospital for Women,..... 1
Homœopathic Medical College and Hospital..... 1
College of Physicians and Surgeons,..... 1
Ohio, Cincinnati College of Medicine and Surgery,..... 1
Eclectic Med. Institute, Cincinnati,..... 1

Pennsylvania, Med. Dep. of University of Pennsylvania,..... 3
Jefferson Medical College, Philadelphia,..... 3
Medico-Chirurgical College, Philadelphia,..... 1
Woman's Medical College of Pennsylvania,..... 1

Names of the Institutions from which the *unsuccessful* candidates were graduated.

Austria, Med. Dep. of University of Cracow,..... 1
Canada, Med. Dep. of University of Toronto,..... 1
Italy, Med. Dep. of University of Naples,..... 1
United States.
Georgia, Atlanta Medical College,..... 1
Michigan, Med. Dep. of State University,*..... 1
New Jersey, Medical and Surgical College of New Jersey,..... 1
Licentiate from New Jersey State Board of Medical Examiners,..... 1
Ohio, Cleveland Hom. Medical College 1

Five of the unsuccessful candidates were examined by the State (old school) Board; two by the Homœopathic, and one by the Eclectic Board.

The Establishment of Two Separate Educational Tests Under State Supervision, by the Provisions of the Medical Laws of the State of New York.

The New York system provides for the application of separate educational tests.

The *first*, applied by the Regents, shows that the applicant has complied with the provisions of the *preliminary* educational requirements.

The *second*, applied by the state examining boards, shows that the applicant possesses a satisfactory knowledge of medicine.

The foregoing tabulation shows that the application of the *first* test by the Regents resulted in the rejection of thirteen out of eighty-seven candidates (16 per cent).

The application of the *second* test by the examining boards, shows that eight of eighty-seven candidates (9 per cent.), were disqualified by reason of defective medical training.

The joint application of these two tests, taking account only of failures through defective educational qualifications, both medical and academical, shows that twenty-one applicants, more than *twenty-four per cent.* were *not* deemed competent to enter upon the responsible duties of active professional work; yet nearly every one of these applicants had complied with *all* the requirements of medical learning considered sufficient under tests recognizing the *diploma* as the standard of a requisite amount of medical knowledge.

* Detected in attempted fraud during the examination.

The authors of this reformatory work were confident that its conservative and helpful tendencies would measurably *diminish* the influx of improperly qualified practitioners, by establishing an effective barrier against fraud and favoritism. The most sanguine of them, however, were not prepared for positive evidences of incompetency on the part of so large a proportion of the applicants as these records reveal.

The Scope, Purposes, and Provisions of the Medical Educational Systems of the State of New York.

The supporters of this desirable and perfected educational system, by the enactment of present laws, have aimed at establishing the following provisions:

First. The requirement of evidence of *preliminary educational qualifications*, on the part of *all medical students prior* to an entrance upon medical studies, in this state, the evidences thereof to be determined *by the State Department of Education*, and not by a faculty of a medical college.*

Second. The requirement of evidence of proper *academical* knowledge on the part of *all practitioners* coming from other states and proposing to enter upon the practice of medicine in the state; the evidences thereof to be also determined by and under the auspices of the State.

Third. The requirement of evidence of the possession of a practical knowledge of medicine on the part of *every practitioner*, before entering upon practice in this state, such evidence to be determined, not by a faculty of a medical college, but by state examining and licensing boards, after an impartial and satisfactory examination thereunder.†

*It is to be noted, that for a number of years a preliminary educational law has been in force, the provisions of which require *all* students, *prior* to an entrance upon the *study of law*, to furnish the Regents with credible evidence showing educational qualifications such as are now required of all medical students; and as showing a tendency to require still greater proficiency, it is observable that the standard for law students was last year, by order of the Court of Appeals, advanced, from studies required for entrance to a High School, to studies equivalent to the *middle* of a High School course.

Furthermore, it is hoped that the same advanced standard will be, in the near future, applied to medical students; and also, that this will be still further advanced until a standard is attained equivalent to a *completed* High School course or to that required for entrance to a college of arts.

†Vide the decision of the Supreme Court of Montana, Article III. of this series entitled "The Constitutionality of Laws Creating State Medical Examining Boards," etc., in which the following decisions are stated:

"But there is no arbitrary deprivation of such right (the right to pursue any lawful calling or profession), where its exercise is *not* permitted because of failure to comply with conditions *imposed by the State* for the protection of society.

"The power of the *State* to provide for the general welfare of its people authorizing it

Fourth. The appointment to membership in the examining and licensing boards to be *controlled* by the *profession*, while being conducted under the supervision, direction, and authority of the *State Department of Education.*

Fifth. While exact and complete *uniformity of standards* is secured, the provision is made for the supervision and control of the examination and licensing of candidates by representatives of each recognized system *separately;* thereby permitting each to superintend, conduct, and complete its own educational affairs and interests, dissociated from any embarrassing relations with the representatives of either of the other two schools of medicine.

That these several necessary and desirable provisions are satisfactorily applied; and that the thorough and impartial application thereof, is contributing to the *unification* and permanent *elevation* of standards of medical learning, the foregoing figures furnish most convincing proof; and also show, with forceful effectiveness, not only the desirableness, but the actual necessity for supporting, with increased zeal and heartiness, the thoroughly effective tests established under the admirably constructed and eminently practical, impartial, and non-partisan system of medical laws of the State of New York.

The Principles and Practical Benefits Derivable from the New York System.

While the work which our board has in hand is new and measurably experimental, the principle underlying the method of determining medical educational standards, viz., under *state supervision* and authority, is by no means an untried one.

It is in vogue in Canada and in all European countries, where it is well established, and is recognized as a far safer conservator of public welfare, and more uniformly effective in application than the present system generally adopted in this country.

---

to prescribe all such regulations as in *its* judgment will secure or tend to secure them against the consequences of ignorance and incapacity as well as of deception and fraud.

"As one means to this end it has been the practice of States from time immemorial to exact, in many pursuits, a certain degree of skill and learning, upon which the community may confidently rely, their possession being generally ascertained upon an *examination of parties by competent persons*, or inferred from a certificate to them in the form of a diploma or license from an institution established for instruction on the subjects, scientific and otherwise, with which such pursuits have to deal.

"The nature and extent of the qualifications required must depend primarily upon the *judgment of the State* as to their necessity. If they are appropriate to the calling or profession, and attainable by reasonable study or application, *no objection to their validity can be raised because of their stringency or difficulty.*"

The law providing three state boards of medical examiners represents the *principle* for which we struggled—that of divorcing the teaching from the licensing power, and placing it where it properly belongs, under the *auspices of the Educational Department of the State*; hence, it affords the best possible opportunity for enabling the profession to attain higher and more nearly uniform standards of medical learning.

The system inaugurated in New York State, however, has this advantage over that of all others in this or any other country, in that while it affords ample protection to the public, it also provides effective means, for permitting the three representative schools *separately* to exercise the civil right to conduct, control and complete, each under its own supervision, yet under conditions and standards applicable to all alike, its own medical educational affairs.

And it is the crowning merit of this perfected system, that the details and entire executive management of this complex method are placed under the charge of a body of experienced, impartial and unprejudiced educators—the Regents of the University of the State of New York.

WILLIAM M. L. FISKE, M. D.

Was born in New York City, in the year 1841, and is descended from one of the earliest and most honored of the New England families, which furnished the first four graduates of Yale. After a thorough Academical education and preparation for college, from force of circumstances he was obliged to abandon further study, but after three years of mercantile life he resumed the study of his chosen profession and entered the New York Medical college in 1860. Upon the opening of the Bellevue Medical college, he followed Prof. R. Ogden Doremus to that college, graduating in its second class, that of 1863. During this period and between his college courses he enlisted in Co. A, 47th Regt., N. Y. S. V., was promoted to Hospital Steward, and afterwards by Gen. Morris appointed Acting Assistant surgeon of the Post Hospital, retaining that position during the remainder of the regiment's service. He was afterwards appointed by competitive examination upon the Bellevue staff, remaining at the Charity Hospital for eight months. Immediately after his graduation he entered the office of Dr. Albert Wright as a student of homœopathy and graduated in the following year from the New York Homœopathic Medical college.

After practicing a few months, he again presented himself to the Army Examining Board in New York, passed and received an appointment as Acting Assistant Surgeon,remaining in the service until the close of the war. After practicing in the West for seven years, at the earnest solicitation of his old preceptor, Dr. Wright, he abandoned an increasing practice and returned to Brooklyn, entering into partnership with Dr. Wright which lasted until the latter's death. Dr. Fiske associated himself with the chair of Surgery in the Brooklyn Homœopathic Dispensary in 1870. Upon the institution of the Brooklyn Homœopathic Hospital he became one of the surgeons on its staff, and upon the death of Dr. A. E. Sumner in 1882 was unanimously elected his successor as Chief of Staff and Medical Director of the hospital. He was one of the founders and organizers of the Brooklyn E. D. Homœopathic Dispensary, and for years the President of its Board of Trustees. He was one of the organizers and lecturers of the Training School for Nurses of the Brooklyn Maternity, also of the Homœopathic Hospital Training School, and continued his services until compelled reluctantly to relinquish them on account of his large and constantly

increasing private practice. He is a member and ex-president of the Kings County Homœopathic society, and a senior member of the American Institute.

The career of Dr. Fiske has been a remarkably successful one, but its success has not been easily won. It is the legitimate reward of that patient, hopeful industry and selfdenial which are the foundation stones of all advancement in any walk of life ; in any business or profession.

A lover of his fellow man and a believer in human liberty and human progress, he has been a life-long adherent to the principles of true Republicanism, though never an active politician.

CONSTITUTION AND BY-LAWS.

CONSTITUTION.

ARTICLE I.—NAME.

§ 1. In pursuance of Chap. 268, Laws of 1862, by which it was incorporated, this association shall be known as the Homœopathic Medical Society of the State of New York.

§ 2. Its object shall be the advancement of homœopathic therapeutics and of all other departments of medicine and surgery.

ARTICLE II.—MEMBERS.*

The society shall be composed of permanent members, of delegates from homœopathic county societies and corporate institutions or associations of this state, and of such other members as may be chosen in conformity with the By-Laws.

ARTICLE III.—OFFICERS.

§ 1. The officers of this society shall be a president, three vice-presidents, a secretary, treasurer, necrologist and twelve censors (three of whom shall be selected from each of the four Censorial Districts of the state), who shall be elected by ballot by a majority of the active members present at each annual meeting.

§ 2. Their term of office shall commence at the close of the meeting at which they are elected, and shall continue for one year, until the adjournment of the next annual meeting, and until their successors are elected.

ARTICLE IV.—SEAL.

The subjoined, either printed or embossed, shall be the official seal of the society.

*This society "may elect such a number of permanent, delegate or other members as may be provided for by the constitution and by-laws," and is "empowered to regulate and control its own membership." Laws of 1862, Chap. 209.

ARTICLE V.—MEETINGS.*

§ 1. The annual meeting shall be held each year at Albany, commencing on the second Tuesday in February.

§ 2. A semi-annual meeting may be held at such time and place as the society shall determine.

§ 3. Special meetings may be called by the Executive Board or by the president upon the call of ten active members.

ARTICLE VI.—QUORUM.

Ten active members shall constitute a quorum.

ARTICLE VII.—AMENDMENT.

Any article of this Constitution may be amended at an annual meeting by a two-thirds vote of the active members present, provided that a written notice shall have been given at the preceding annual meeting.

---

*This society may select the time and place for holding its annual, and other, meetings. Laws of 1875, chap, 449.

BY-LAWS.

ARTICLE I.—DUTIES AND ELECTION OF OFFICERS.

§ 1. The duties and responsibilities of the president, vice-presidents, secretary, treasurer and necrologist shall be such as are usually incident to these offices.

§ 2. The President shall deliver an address at the annual or semi-annual meeting, appoint standing committees, bureaus and delegates, make appointments to fill vacancies and be *ex-officio* member of all committees.

§ 3. The Secretary, in addition to his other duties, shall annually edit the Transactions of the Society and the State Directory of Homœopathic Physicians, consulting with the Executive Board when he or they deem it necessary. He shall divide the delegate members into four classes as nearly equal as possible, one of which classes shall go out of office each year.

He shall be paid a salary of two hundred and fifty dollars per annum.

§ 4. The Treasurer shall keep the funds of the society in a bank or trust company approved by the Executive Board, and the account shall stand in the name of the society.

Each year he shall furnish a copy of the current issue of the Transactions to each permanent and senior member in good standing, and shall send to each county society not in arrears as many copies as it is entitled to delegates.

At each regular meeting he shall announce the names of such applicants as shall have failed to qualify for membership.

At each annual meeting he shall report the names of such members, institutions and county societies as are dropped for non-payment of dues, and shall furnish the tellers with a list of the active members entitled to vote.

He shall turn over to his successor all property of the society in his charge.

In lieu of salary he shall be reimbursed for his traveling expenses incurred in attending the meetings of the society.

§ 5. It shall be the duty of the Censors to consider all applications

for permanent membership, reporting to the society at the same or next meeting such as they judge to be properly qualified for election.

Three shall constitute a quorum.

§ 6. Officers shall be voted for together on a ballot to be deposited, by each active member voting, between the hours of eleven and twelve o'clock in the morning of the second day of the annual meeting.

Within one hour after the closing of the poll the tellers shall make a report.

In case of failure to elect, another ballot for the office or offices to be filled shall be ordered held at once or at a subsequent session.

The tellers shall receive no ballot unless notified by the treasurer that the member wishing to vote has paid his or her dues, in evidence of which shall be the list furnished the tellers by the treasurer or his receipt for the dues in question.

ARTICLE II.—MEMBERSHIP.

§ 1. By the term "active members" is meant such permanent, delegate and senior members as are in good standing.

§ 2. Any physician desiring permanent membership must be of good moral and professional standing, and legally licensed to practice medicine under the laws of this State.

The candidate must sign the following form, properly filled out and indorsed: "I request membership in the Homœopathic Medical Society of the State of New York, and agree, if elected, to pay my dues promptly and regularly to the society. I hereby acknowledge that I believe *Similia Similibus Curantur*. I reside at No. ..... in....., county of ....., and am a graduate of.....in the year.... [signed] [date.] The undersigned permanent members indorse the above applicant as worthy of permanent membership in this society. [Signed].... .....and.....

After having been favorably reported on by the Censors and accepted by a majority vote of the active members present at a regular meeting, the candidate, upon the payment of three dollars, shall become a permanent member, entitled to the rights and privileges of membership except that a further fee of two dollars will be charged those desiring a certificate of membership.

If the first year's dues be not paid before the regular meeting next succeeding his or her election, such election shall be void and his or her name shall be published each year in a special list in the back of the Transactions.

The first, second, third and fourth paragraphs of this section shall be printed upon the application blanks.

§ 3. Each homœopathic county society in this state is entitled to elect, for a term of four years, as many delegate members of this society as there are assembly districts in that county.

Each incorporated homœopathic institution or association in this state shall be entitled, upon payment of the annual dues, to single delegate representation in this society, the term of the delegate to be four years.

Delegate members in good standing have all the rights and privileges of permanent membership except the certificate, eligibility to senior membership and election to the presidency.

§ 4. Any permanent member sixty or more years of age may be elected a senior member at an annual meeting, provided that at the time of such election he or she is in good standing and shall have paid dues for twenty years.

Senior members shall be exempt from dues and assessments, and shall be entitled to all the rights and privileges of membership.

§ 5. Any physician or surgeon not a resident of this state, who has manifested superior attainments in medicine or one of its collateral sciences, may be elected an honorary member at an annual meeting, provided that the nomination, accompanied by reasons for conferring the honor, shall have been made at a previous regular meeting. Not more than three honorary members shall be elected in any one year.

Honorary members may participate in the proceedings of this society (except that they shall not vote nor be eligible to office), and are requested to contribute papers. They shall be entitled to receive gratis the volumes of Transactions to which they contribute papers.

ARTICLE III.—DUES.

§ 1. The annual dues shall be three dollars from each permanent member and from each institution or association which appoints a delegate; from each county society there shall be due three dollars per annum for each delegate to which that society is entitled.

§ 2. Each permanent member shall pay a membership fee of three dollars, which shall include the dues for the current year, at the time of his or her election.

§ 3. No member in arrears shall be entitled to the privileges of membership.

Members three years in arrears shall be dropped from the roll, and

their names published each year in a special list as having been dropped for non-payment of dues.

Article IV.—Committees and Bureaus.

§ 1. The Executive Board, consisting of the president, vice-presidents, secretary and treasurer, shall act as the executive committee of the society, attending to matters not otherwise provided for, or that may be referred to it.

When necessary it may call a special meeting of the society, specifying time, place and object.

It shall serve as an advisory committee of publication with discretionary power as to the appearance in the Transactions of any given report or paper.

§ 2. The president-elect shall annually appoint the chairman of the Committee on State Medical Examiners and a chairman, with at least two members, of the Committee on Legislation and of each of the following bureaus: Materia Medica, Clinical Medicine and Pathology, Surgery, Obstetrics, Gynæcology, Pædology, Mental and Nervous Diseases, Ophthalmology and Otology, Laryngology and Rhinology, and Public Health.

Article V.—Papers.

§ 1. All papers, communications and reports read before or presented to this society become thereby its property, and must be at once deposited with the secretary. They may afterward, by means of copies, be published in medical journals if due credit be given to this society.

§ 2. No paper or report shall be received for publication in an unfinished condition.

Article VI.—Regents' Degree.*

§ 1. This society may at each annual meeting recommend the names of four medical practitioners to the Regents of the University of the State of New York for the honorary degree of Doctor of Medicine, providing that the respective candidates be of good professional and moral standing, and shall have attained the age of forty-five years.

§ 2. After open nominations, each accompanied by reasons why the honor should be conferred, each member present may vote on one ballot for not more than four of the nominees, and only such names

*Laws of New York, 1889, chap. 529, title III. § 1.

as on this ballot receive two-thirds of the votes of the members present, shall be presented to the Regents.

ARTICLE VII.—STATE MEDICAL EXAMINERS.*

§ 1. This society shall at each annual meeting, by a majority vote, nominate to the Regents of the University for appointment as State Medical Examiners at least twice as many persons as there are appointments to be made.

§ 2. Each nominee must be a member of this society in good standing; must have been graduated in course from a reputable medical college, and must have been practicing medicine or surgery under the laws of this State for at least five years immediately prior to the first of July following said nomination.

§ 3. The committee on State Medical Examiners shall send to each permanent and delegate member of this society, not more than three nor less than two weeks before the annual meeting, a list of at least three times as many nominees as there are appointments to be made.

Each active member present may, between eleven and twelve o'clock in the morning of the second day of the annual meeting, deposit with two special tellers appointed by the president, a ballot for at least twice as many nominees as there are appointments to be made. Such names as receive a majority of the votes cast shall be presented to the Regents.

In case a sufficient number of names (twice the number of appointments to be made) do not receive a majority vote, the quota shall be filled by a ballot upon names submitted in open nomination.

§ 4. If charges of unprofessional or dishonorable conduct or continued neglect of duty are made against any State Medical Examiner representing this society, the society, after considering the matter in Committee of the Whole, may by a majority vote at any regular or special meeting submit the evidence in the case to the Regents and may request the removal of said Examiner.

§ 5. The Committee on State Medical Examiners shall consist of five members, to be elected by ballot at the annual meeting. The chairman shall be appointed from among their number by the president-elect within three weeks. Their term of office shall commence at the close of the meeting at which they are elected and shall continue one year, to the close of the next annual meeting, and until their successors are elected.

*Laws of New York, 1890, chap. 507.

Article VIII.—Order of Business.

At the meetings of this society the following shall be the Order of Business, unless otherwise prescribed by the Executive Board or changed by the society.

Prayer.
Communication from the President.
Appointments:
- Committee on Attendance,
- Committee on President's Address,
- Auditing Committee,
- Tellers.

Minutes of the last meeting.
Report of the Board of Censors.
Elections:
- of Members—Permanent, Senior, Honorary;
- of Nominees for the Regent's Degree;
- of Officers (at time specified);
- of Nominees as State Medical Examiners (at time specified);

Reports:
- of Officers;
- of Committees;
- of Bureaus.

Miscellaneous Business.

Article IX.—Government.

This society shall be governed by the Code of Ethics adopted by the American Institute of Homœopathy, and by parliamentary usage as set forth in Roberts' Rules of Order for Deliberative Assemblies.

Article X.—Amendment.

These By-Laws may be amended by a two-thirds vote of the active members present at an annual meeting, provided that written notice shall have been given at a previous regular meeting.

NOMINEES FOR THE REGENTS' DEGREE.

1863.
*Frederick F. Stamm, Brooklyn.
1867.
*M. M. Matthews, Rochester.
1872.
Alfred W. Gray, Milw'kee, Wis.
Caspar Bruchhausen, Norwich,
Wm. B. Reeve, Quogue.
1875.
*Constantine Hering, Phil'a, Penn.
1876.
*John F. Gray, New York.
1877.
*Carroll Dunham, Irvington.
Wm. Gulick, Watkins.
*H. V. Miller, Syracuse.
W. H. Watson, Utica.
1878
E. P. Fowler, New York.
Egbert Guernsey, New York.
*C. Ormes, Jamestown.
*Chas. Sumner, Rochester.
1879.
*Edward Bayard, New York.
Asa S. Couch, Fredonia.
*A. W. Holden, Glens Falls.
L. M. Pratt, Albany.
1880.
W. C. Doane, Syracuse.
O. Groom, Horseheads.
Henry Minton, Brooklyn.
A. R. Wright, Buffalo.
1881.
A. S. Ball, New York.
C. T. Harris, Syracuse.
*E. H. Hurd, Rochester.
H. M. Paine, Albany.
1882.
E. Darwin Jones, Albany.
*Chas. E. Swift, Auburn.
1883.
*John W. Dowling, New York.
*L. M. Kenyon, Buffalo.
John J. Mitchell, Newburgh.
Reuben C. Moffat, Brooklyn.
1884.
Timothy F. Allen, New York.
*S. P. Burdick, New York.
1886.
*Titus L. Brown, Binghamton.
Edward S. Coburn, Troy.
Everitt Hasbrouck, Brooklyn.
*Samuel Lilienthal, New York.
1887.
Wm. Tod Helmuth, New York.
Henry C. Houghton, New York.
1888.
Wm. M. L. Fiske, Brooklyn.
Selden H. Talcott, Middletown.
1890.
E. C. Low, Plattsburgh.
1891.
H. M. Dayfoot, Rochester.
J. T. Greenleaf, Owego.
1892.
N. B. Covert, Geneva.
Harrison Willis, Brooklyn.
M. W. Van Denburg, Fort Edward.

HONORARY MEMBERS.

Elected.	
1886	Allen, H. C., Chicago, Ill.
1890	Bartlett, Clarence, Philadelphia, Penn
1887	Biggar, H. F., Cleveland, O.
1882	Blake, J. Gibbs, England.
1881	Breyfogle, W. L., New Albany, Ind.
1881	Budlong, J. C., Providence, R. I.
1888	Clifton, Arthur C., Northampton, Eng.
1879	Cook, E. G., Chicago, Ill.
1883	Corbin, J. L., Athens, Penn.
1868	Cropper, Chas., Lebanon, O.
1868	Cullis, Chas., Boston, Mass.
1881	Dake, J. P., Nashville, Tenn.
1881	DeDerkey, F. F., Mobile, Ala.
1870	Drummond, John, Manchester, Eng.
1867	Dudgeon, R. E., London, Eng.
1869	Duncan, T. C., Chicago, Ill.
1870	Edie, John J., Leavenworth, Kan.
1881	Gallinger, J. H., Concord, N. H.
1888	Gilchrist, J. G., Iowa City, Ia.
1880	Guilbert, E. A., Dubuque, Ia.
1865	Hale, E. M., Chicago, Ill.
1882	Hayward, John W., Liverpool, Eng.
1868	Heath, Edwin R., Dayton, O.
1869	Henderson, William, Edinburgh, Scot.
1871	Hirschel, B., Dresden, Saxony.
1868	Holcomb, Wm. H., New Orleans, La.
1879	Houghton, Henry A., Boston, Mass.
1868	James, Bushrod W., Philadelphia, Pa.
1882	Jones, Samuel A., Ann Arbor, Mich.
1893	Kinne, Th. Y., Paterson, N. J.
1891	Linnell, E. H., Norwich, Conn.
1874	Ludlam, R., Chicago, Ill.
1870	Madden, H. R., London, Eng.
1873	Mandeville, F. B., Newark, N. J.
1884	McGeorge, Wallace, Woodbury, N. J.
1872	McKnight, C. G., Providence, R. I.
1869	Morgan, John C., Philadelphia, Penn.
1882	Peck, Geo. B., Providence, R. I.

1871 Pope, Alfred C., Lee, Eng.
1881 Potter, Samuel, Milwaukee, Wis.
1871 Roth, Mathias, London, Eng.
1882 Runnels, O. S., Indianapolis, Ind.
1865 Sanders, J. C., Cleveland, O.
1878 Skinner, Thomas, London, Eng.
1875 Sparhawk, G. E. E., Burlington, Vt.
1864 Talbot, I. T., Boston, Mass.
1886 Vernon, Elias, Hamilton, Can.
1888 Wesselhoeft, Conrad, Boston, Mass.
1883 Whittier, D. B., Fitchburg, Mass.
1865 Wilson, David, London, Eng.
1891 Wood, James C., Ann Arbor, Mich.
1870 Woodvine, Denton G., Boston, Mass.
1873 Worcester Samuel, El Cajou, Cal.

DIED.

Dec. 27, 1891, T. S. Armstrong, 66 Binghamton.
Jan. 9, 1892, C. A. Bacon, 55, Florida.
Jan. 15, 1892, J. W. Dowling, 54 New York.

HOMŒOPATHIC STATE BOARD OF MEDICAL EXAMINERS.

(To serve until 1893).

J. McE. Wetmore. Jay W. Sheldon.

(To serve until 1894).

W. S. Searle, A. S. Couch, H. M. Paine.

(To serve until 1895).

A. R. Wright, E. H. Wolcott.

OFFICERS, 1850—1891.

Year.	President.	1st Vice-President.	2d Vice-President.	3d Vice-President.	Secretary.	Treasurer.	Cor. Secretary.
1850.	Isaac M. Ward, Newark. N. J.	*D. Chase.	*R. S. Bryan.	A. S. Ball.	Henry D. Paine.		
1851.	*F. Vanderbergh, New York.	*L. Clary.	†F. Humphreys.	Geo. W. Lewis.	"		
1852.	*Lyman Clary, Syracuse.	Alonzo S. Ball.	*S. H. Coburn.	*D. Chase.	"		
1853.	Alonzo S. Ball, New York.	*N. H. Warner.	S. S. Guy.	L. B. Wells.	"		
1854.	*Amherst Childs, Waterloo.	*Henry Adams.	*Josiah Bowers.	*E. T. Richardson.	"		
1855.	Samuel S. Guy, Brooklyn.	*M. M. Matthews.	*R. S. Bryan.	David Springsteed.	"		
1856.	*M. M. Matthews, Rochester.	*J. M. Quinn.	*Henry Adams.	L. B. Wells.	"		
1857.	*R. S. Bryan, Troy.	*A. P. Cook.	L. B. Wells.	†J. C. Peters.	"	J. W. Cox.	
1861.	*Ethan A. Potter, Oswego.	*Simeon A. Cook.	A. R. Wright.	*Cornelius Ormes.	Horace M. Paine.	J. W. Cox.	
1862.	*Jacob Beakley, New York.	A. R. Wright.	*E. A. Munger.	W. S. Searle.	"	L. B. Wells.	
1863.	Henry D. Paine, Nutley, N. J.	*William Wright.	C. W. Boyce.	Asa S. Couch.	"	"	
1864.	*Erastus A. Munger, Waterville.	S. S. Guy.	A. R. Morgan.	"	"	"	
1865.	*Abijah P. Cook, Hudson.	*Benj. F. Cornell.	*Benj F. Bowers.	*L. M. Kenyon.	"	"	H. B. Fellows.
1866.	*Horatio Robinson, Auburn.	Lucien B. Wells.	*Wm. B. Stebbins.	*Edgar B. Cole.	"	*J. S. Delavan.	"
1867.	*B. F. Cornell, Moreau Station.	*S. B. Barlow.	William H. Watson.	L. M. Pratt.	H. B. Fellows,	J. W. Cox.	E. D. Jones.
1868.	William H. Watson, Utica.	T. F. Allen.	*T. L. Brown.	*D. F. Bishop.	H. M. Paine,	W. S. Searle.	"
1869.	*William Wright, Brooklyn.	E. B. Holmes.	Henry Minton.	*E. P. K. Smith.	"	"	"
1870.	Lucien B. Wells, Utica.	*Edwin H. Hurd.	*Ezra P. K. Smith.	T. Franklin Smith.	"	"	"
1871.	*John F. Gray, New York.	T. Franklin Smith.	J. C. Raymond.	*A. W. Holden.	"	*J. F. McKown.	"
1872.	H. A. Houghton, Boston, Mass.	*Charles Sumner.	H. S. Hutchins.	G. L. Gifford.	"	Nelson Hunting.	L. M. Pratt.

1873.	E. Darwin Jones, Albany.	*D. F. Bishop.	J. Ralsey White.	R. E. Miller.	*Frank L. Vincent.	Nelson Hunting.	L. M. Pratt.
1874.	*L. M. Kenyon. Buffalo.	*A. E. Sumner.	*S. C. Knickerbocker.	*Henry Sales.	"	*F. L. Vincent.	"
1875.	*A. W. Holden. Glens Falls.	E. M. Kellogg.	*H. V. Miller.	R. S. Bishop.	"	E. D. Jones.	"
1876.	T. F. Allen, New York.	A. R. Wright.	William Gulick.	Henry R. Stiles.	Alfred K. Hill.	*F. L. Vincent.	"
1877.	Egbert Guernsey, New York.	William Gulick.	Henry R. Stiles.	H. D. Brown.	"	E. S. Coburn.	H. L. Waldo.
1878.	William Gulick, Watkins.	A. R. Wright.	W. M. L. Fiske.	A. P. Throop.	"	"	"
1879.	Asa S. Couch, Fredonia.	Alfred K. Hills.	E. Hasbrouck.	J. J. Mitchell.	H. L. Waldo.	"	*A. P. Hollett.
1880.	A. R. Wright, Buffalo.	E. Hasbrouck.	N. Osborne.	R. A. Adams.	"	"	"
1881.	Selden H. Talcott, Middletown.	J. J. Mitchell.	A. J. Frantz.	*G. W. Peer.	*A. P. Hollett.	"	C. E. Jones.
1882.	J. J. Mitchell, Newburgh.	E. Hasbrouck.	W. B. Kenyon.	W. M. Butler.	"	"	NECROLOGIST.
1883.	Everitt Hasbrouck, Brooklyn.	W. B. Kenyon.	A. P. Williamson.	L. A. Clark.	"	"	*A. W. Holden.
1884.	Edward S. Coburn, Troy.	Henry C. Houghton.	H. M. Dayfoot.	*A. P. Hollett.	John L. Moffat.	H. L. Waldo.	"
1885.	M. O. Terry, Utica	*A. P. Hollett.	N. B. Covert.	George M. Dillow.	"	E. S. Coburn.	"
1886.	Henry C. Houghton, New York.	F. Park Lewis.	*T. L. Brown.	E. W. Bryan.	H. M. Dayfoot.	"	"
1887.	Horace M. Paine, Albany.	Wm. Tod Helmuth.	J. M. Lee.	Geo. E. Gorham.	"	"	"
1888.	Wm. Tod Helmuth, New York.	Thos. D. Spencer.	L. A. Bull.	John L. Moffat.	"	Arthur B. Norton.	"
1889.	Herbert M. Dayfoot, Rochester.	F. F. Laird.	J. T. Greenleaf.	Sidney F. Wilcox.	John L. Moffat.	"	H. L. Waldo.
1890.	George M. Dillow, New York.	N. B. Covert.	J. M. Lee.	W. B. Gifford.	"	"	"
1891.	F. Park Lewis, Buffalo.	A. B. Norton.	L. L. Brainard.	J. W. Sheldon.	"	Chas. Deady.	H. D. Schenck.
1892.	Wm. M. L. Fiske, Brooklyn.	L. A. Bull.	E. J. Bissell.	J. W. Candee.	"	"	"

*Deceased. †Expelled.

MEMBERS DROPPED FOR NON-PAYMENT OF DUES.

(*By-Laws, Article III. Section 3, Paragraph 2.*)

Bass, E. C.....1884
Beach, G. H.....1884
Bigelow, J. G.....1884
Blodgett, T. L.....1884
Bloss, R. D.....1884
Boyce, C. W.....1885
Bradner, Ira S.....1889
Brown, H. D.....1884
Bull, A. T.....1884
Campbell, C. E.....1891
Campbell, M. W.....1884
Carr, A. B.....1892
Clark, A. J.....1889
Coffin, W. H.....1888
Dods, A. Wilson.....1888
Doolittle, J. F.....1889
Finch, Joseph.....1887
Fulford, G. H.....1888
Fuller, H. E.....1890
Gallup, M. W.....1889
Gifford, B. R.....1890
Gifford, G. A.....1884
Grant, B. F.....1888
Greeley, G. H.....1884
Gwynn, W. M.....1884
Hale, C. D.....1888
Hanford, S. C.....1884
Hanford, W. H.....1884
Hawley, W. A.....1884
Hibbard, G. C.....1884
King, G. H.....1888
Lewis G. W. Jr.....1892
Linendall, R. A.....1889
Linsley, John S.....1887
Long, Wm. E.....1892
Loomis, E.....1883
Lowrey, C.....1884
McPherson, J. C.....1892
Miller, Isaac.....1886
Millspaugh, C. F.....1890
Moore, J. de V.....1892
Morgan, E. J., Jr.....1887
Mosher, Chas. M.....1892
Nash, E. B.....1890
Otis, Clark.....1892
Owen, Ira C.....1884
Palmer, G. B.....1890
Peckham, J. J.....1888
Peterson, O. W.....1889
Raymond, J. C.....1883
Reynolds, P. L. F.....1884
Rice, A. B.....1886
Stobbs, A. V.....1888
Sweeting, M. F.....1884
Swift, Chas. L.....1884
Thorn, Sarah E.....1892
Tracy, G. A.....1888
True, R. S.....1892
Truman, I. P.....1889
Voak, J. B.....1891
Wallace, A. E.....1884
Ward, H. J.....1884
Warren, S. C.....1884
Welch, C. D.....1891
Wellman, W. I.....1888
West, James A.....1892
White, J. N.....1884
White, W. Hanford.....1888
Williamson, B.....1888
Woodbury, W. L.....1886
Wright, F. M.....1890
Zoller, W.....1888

MEMBERS-ELECT WHO FAILED TO QUALIFY.

Chaplain, F. T.....1891
Gifford, Alden.....1892
Gwynn, Chas. A.....1892
Madden, J. D.....1891
Read, J. S.....1891
Zimmermann, Chas.....1892

PERMANENT MEMBERS.

(*Senior Members in Small Capitals.*)

		Elected.
Adams, Myron H.	56 Park Ave., Rochester,	1892
Adriance, F. W.	306 Lake, Elmira,	1883
Albertson, Chas. S.	358 Richmond Ave. Buffalo,	1891
Allen, George	Middletown,	1883
Allen, Paul	10 E. 36th, New York,	1892
Allen, T. F	10 E. 36th, New York,	1879
Alling, D. G	Dunkirk,	1891
Arthur, Daniel H.	Middletown,	1891
Atwood, J. Freeman	149 Greene Ave. Brooklyn,	1883
Avery, Edward W	16 Hancock, Brooklyn,	1889
Babbitt, Otis H	Cooperstown,	1892
Baker, Jennie V. H.	512 Bedford Av. Brooklyn,	1889
BALL, ALONZO S. (1887)	56 W. 53d, New York,	1863
Ball, Halsey J	126 W. 129th, New York,	1891
Barkeloo, Harriet	915 Third Ave., Brooklyn,	1889
Banker, Pierre A.	Elizabeth, N. J.,	1887
Barnard, J. S.	Clyde,	1886
Barnes, W. H.	Chatham,	1872
Baylies, B. L'B.	418 Putnam Ave., Brooklyn,	1883
Beach, Eliza J	Pasadena, Cal.,	1875
Beebe, Clarence E	15 E. 38th, New York,	1888
Bell, Willard N.	6 Greene, Ogdensburgh,	1890
Bennet, G. H. R	21 S. Portland Ave., Brooklyn,	1889
Benson, Russell F. Jr.	2 St. Paul Pl. Troy,	1886
Bergen, A. Winfred	Cornwall-on-Hudson,	1891
Berghaus, Alexander,	138 E. 65th, New York,	1888
Billings, G. H.	Cohoes,	1875
Birdsall, S. T.	80 Ridge, Glens Falls,	1883
Birdsall, T. P	Patterson,	1892
Bishop, Francis M.	Newark Valley,	1891
Bissell, Elmer J	75 S. Fitzhugh, Rochester,	1889
Blackman, W. W.	519 Clinton Ave., Brooklyn,	1890
Bleecker, Wm. H.	240 Van Siclen Ave., Brooklyn,	1892
Blighton, W. V-R. (Lic.)	60 Oliver, N. Tonawanda,	1891
Bolan, Lorenzo W	679 Greene Ave., Brooklyn,	1890
Boocock, Robert	Flatbush,	1892
Bonnell, Chas. L.	3 Hanson Pl. Brooklyn,	1879

		Elected.
Borden, G. T.	Caledonia,	1887
Boyle, Chas. C.	6 E. 34th, New York,	1888
Boynton, F. H.	34 W. 32d, New York,	1888
Brainard, L. L.	2 Cronkhite Block, Little Falls,	1883
Brayton. S. N.	202 Delaware Ave., Buffalo,	1886
Brinkman, Mary A.	219 W. 23d, New York,	1891
Brown, E. V.	N. Tarrytown,	1886
Brown, M. Belle	135 W. 34th, New York,	1892
Brown, W. B.	Palmyra,	1871
Bryan, E. W.	Corning,	1880
Buchholz, Louise Z.	99 7th, New York,	1892
Buell, Jessie W.	61 S. Clinton, Rochester,	1889
Bull, Louis A.	160 Franklin, Buffalo,	1886
BULLARD, D. H..(1887)	Glens Falls,	1864
Bulmer, Geo. W.	1210 Bushwick Ave., Brooklyn,	1891
Burdick, Mrs. Alice H.	347 W. 34th, New York,	1892
Burnham, Clark	182 Clinton, Brooklyn,	1889
Butler, Wm. M.	507 Clinton Ave., Brooklyn,	1881
Caldwell, Frank E.	151 Henry, Brooklyn,	1889
Calkins, T. T.		1868
Campbell, E. E.	Alexandria Bay,	1892
Candee, J. W.	402 Warren, Syracuse,	1885
Carleton, Bukk G.	173 W. 47th, New York,	1892
Carroll S. W.	228 State, Albany,	1874
Case, Walter R.	239 Mill, Poughkeepsie,	1886
Cassidy, Georgia A.	703 Nostrand Ave., Brooklyn,	1891
Chamberlain, J. H.	Belfast,	1887
Chapin, Edward	21 Schermerhorn, Brooklyn,	1883
Chase, C. E.	134½ Park Ave., Utica,	1882
Chase, J. Oscoe	214 E. 53d, New York,	1888
Church, Geo. H.(Lic.)	Oak's Corners,	1891
Clapp, W. F.	Fairport,	1890
Clark, Byron G.	162 W. 122d, New York,	1891
Clark, Frank Wake	Williamson,	1891
Clark, L. A.	Cambridge,	1879
Coburn, Edward S.	91 Fourth, Troy,	1874
Cole, Directus D.	101 Main, Albion,	1883
Collins, Newton M.	43 East Ave. Rochester,	1886
Colton, H. E.	362 Pearl, Buffalo,	1891
Cook, C. P.	Hudson,	1872
Cook, Joseph T.	138 Delaware Ave. Buffalo,	1883

		Elected.
Cooke, Mrs. H. N. F.	250 W. 22d, New York,	1892
Cornell, Clarence W.	354 W. 58th, New York,	1884
Cornell, Geo. B.	192-a Sixth Ave. Brooklyn,	1890
Corwin, Elizabeth.	Binghamton,	1892
Couch, Asa S.	Fredonia,	1864
Covert, N. B.	Geneva,	1878
Covert, Rynear B.	Seneca Falls,	1892
Cowl, Walter Y.	In Europe,	1883
Cox, G. A.	80 S. Swan, Albany,	1878
Cox, J. W.	109 State, Albany,	1869
Crandall, E. L.	78 Fourth, Troy,	1885
Curtiss, Alex. M.	334 Pearl, Buffalo,	1883
Dake, Mrs. Abbie.	Geneva,	1889
Danforth, Loomis L.	35 W. 51st, New York,	1888
Davis, John E. L.	34 E. 39th, New York,	1891
Dayfoot, Herbert M.	41 Sophia, Rochester,	1881
Deady, Charles.	110 W. 48th, New York,	1888
Dearborn, Henry M.	152 W. 57th, New York,	1888
Decker, William M.	Kingston,	1883
Demarest, J. H. (Lic.)	1969 Madison Av., New York,	1892
Deschere, Martin.	334 W. 58th, New York,	1889
Deuel, W. Estus.	Chittenango,	1891
Diehl, Wm., Jr.	36 McKibben, Brooklyn,	1891
Dillingham, Thomas M.	46 W. 36th, New York,	1891
Dillow, George M.	102 W. 43d, New York,	1889
Doty, George H.	129 Schermerhorn, Brooklyn,	1892
Doughty, Francis E.	512 Madison Av., New York,	1877
Dowe, Frank Le C.	Bedford Park, New York,	1892
Dowling, John W.	41 W. 45th, New York,	1889
Dutcher, Merritt T.	Owego,	1884
Eden, Samuel.	1340 Bushwick Av., Brooklyn,	1889
Eddy, Ermina C.	500 William, Elmira,	1883
Eife, Arthur F.	175 W. 10th, New York,	1888
Elebash, Clarence S.	228 E. 19th, New York,	1889
Elliot, Amos H.	482 Quincy, Brooklyn,	1890
Elliott, J. B.	493 Clinton Av., Brooklyn,	1878
Erb, Peter.	109 E. Genesee, Buffalo,	1891
Eurich C.	119 E. 86th, New York,	1888
Fancher, Edwin.	16 Orchard, Middletown,	1885
Faust, Louis.	148 Jay, Schenectady,	1885

		Elected.
Fay, Russell P.	80 Warburton Av., Yonkers,	1892
Fisher, E. A.	1039 Filmore Av., Buffalo,	1891
Fiske, Wm. M. L.	484 Bedford Av., Brooklyn,	1875
Flagg, Robert N.	Yonkers,	1889
Follet, William M.	Seneca Falls,	1891
Foster, E. Agate	Patchogue,	1891
Foster, Henry	Clifton Springs,	1891
Foster, Hubbard A.	3 St. John's Pl., Buffalo,	1891
Foster, William E.	Bay Shore,	1892
Fowler, W. P.	63 S. Clinton, Rochester.	1876
Fralick, Wilfrid G.	745 Madison Av., New York,	1892
Franklin, E. D.	331 W. 14th, New York,	1888
Frazier, L. A.	124 Division, Amsterdam,	1892
Frye, Moses M.	Auburn,	1884
Gamman, A. M.	Corning,	1886
Garnsey, W. S.	77 N. Main, Gloversville,	1888
Garrison, J. B	111 E. 70th New York,	1888
Gifford, G. L.	Hamilton,	1868
Gifford, W. B.	Attica,	1886
Gillespie, Lizzie S.	Bedford Av.& S-5th,Brooklyn,	1889
Gillette, Myra A.	Medina,	1891
Givens, Amos J.	Stamford, Conn.,	1891
Goewey, Gatherine E.	213 Hamilton, Albany,	1880
Gore, Jennie E.	163 E. 90th, New York,	1892
Gorham, George E.	160 Hamilton, Albany,	1883
Gorton, David A.	137 Clinton, Brooklyn,	1890
Groves, C. A.	Orange, N. J.,	1886
Greenleaf, J. T.	101 Main, Owego,	1884
Guernsey, Egbert	528 Fifth Av., New York,	1865
GULICK, WILLIAM (1885)	Watkins,	1865
Guy, C. N,	Maine	1885
Hadley, Charles H.	Blythebourne,	1891
Hadley, W. A. M.	188 Franklin, Buffalo,	1891
Haines, Charles T.	27 Main, Binghamton,	1891
Halbert, John Sanford	389 Pearl, Buffalo,	1890
Hallock, J. Henry	414 S. Salina, Syracuse,	1880
Hallock, Lewis	34 E. 39th, New York,	1867
Hamlin, F. W.	231 W. 52d, New York,	1892
Hand, George F.	Binghamton,	1884
Hanford, Harold W.	252 W. 57th, New York,	1892

		Elected.
Hanor, Azro Chace	White Plains,	1888
Hartley, William G	345 W. 34th, New York,	1891
Hasbrouck, Everitt	369 Ninth, Brooklyn,	1873
Hasbrouck, Sayer	369 Weybosset, Provid'e, R. I.,	1883
Hathaway, W. E	Hornellsville,	1886
Haviland, N. H	Fulton,	1880
Hawley, George T	Howell Block, Corning,	1888
Hayward, Edwin S	Rochester,	1890
Haywood, George M	612 West Av., Rochester,	1890
Haywood, Mrs. Julia F	612 West Av., Rochester,	1890
Helfrich, Chas. H	201 E. 23d, New York,	1888
Helmuth, William Tod	299 Madison Av., New York,	1873
Helmuth, W. T., Jr	465 Lexington Av., New York,	1888
Heinemann, J. D	77 E. Eagle, Buffalo,	1887
Hough, Walter D	Niagara Falls,	1891
Houghton, B. L	1395 Bedford Av., Brooklyn,	1885
Houghton, Henry C	7 W. 39th, New York,	1875
Hunt, Dwight B	159 Madison Av., New York,	1887
Hunt, Oren G	205 E. 19th, New York,	1891
Hunting, Nelson	155 Hamilton, Albany,	1872
Hurd, S. Wright	234 Genesee, Lockport,	1891
Hutchins, H. S	Batavia,	1870
Jacobson, Frank A	269 Grand, Newburgh,	1891
Jeffery, George C	343 Jefferson Av., Brooklyn,	1887
Jenks, F. Percy	419 Ninth, Brooklyn,	1890
Johnston, C. L	567 Vanderbilt Av., Brooklyn,	1890
Jones, Chas. E	140 State, Albany,	1878
JONES, E. DARWIN (1886)	140 State, Albany,	1864
Kastendieck, J. T. W	461 Bedford Av., Brooklyn,	1890
Keegan, Wm. A	44 S. Clinton, Rochester,	1890
Keeney, J. H	Oswego,	1886
Kellogg, Chas. M	38 N. Clinton, Rochester,	1889
Kellogg, Edwin M	115 E. 37th, New York,	1866
Kenyon, W. B	86 W. Mohawk, Buffalo,	1883
King, Wm. Harvey	23 W. 53d, New York,	1886
Kinne, A. B	413 Warren, Syracuse,	1882
Kinney, C. Spencer	Middletown,	1883
Knapp, James C	Geneva,	1892
Knapp, Theodore P	Union,	1885
Knight, Stephen H	Detroit, Mich.,	1888

		Elected.
Laird, F. F.	Utica,	1883
Laird, W. T.	Watertown,	1883
Land, Joseph F.	130 W. 126th, New York,	1888
Lane, Irwin J.	2 Church, Sing Sing,	1892
Latimer, Wm. C.	410½ Clinton, Brooklyn,	1884
Lauer, C. F.	241 Schenck, Brooklyn,	1891
Leal, Malcolm	144 W. 48th, New York,	1888
Lee, J. M.	89 Plymouth Av., Rochester,	1884
Lee, Mrs. Sarah I.	89 Plymouth Av., Rochester,	1888
Le Seur, John W.	Batavia,	1890
Lewis, F. Edward	Cambridge,	1891
Lewis, F. Park	188 Franklin, Buffalo,	1881
Lewis, Henry M	171 Remsen, Brooklyn,	1891
Little, G. W.	Glens Falls,	1873
Low, E. C.	Plattsburgh,	1878
MacCallum, John H.	143 Childs, Rochester,	1890
Madden, Joel D.	Sing Sing,	1892
Marsh, James M.	Winthrop,	1891
Martin, G. Forrest	Skaneateles,	1892
Martin, Lynn Arthur	91 Collier, Binghamton,	1892
Martin, Truman J.	143 Bryant, Buffalo,	1891
McCrea, Philip A.	18 West Eagle, Buffalo,	1891
McDowell, Chas	116 W. 13th, New York,	1888
McDowell, Geo. W.	151 W. 130th, New York,	1892
McKinney, Mrs. Susan S.	205 De Kalb Av., Brooklyn,	1883
McManus, G. D.	Oswego,	1869
McMichael, Arkell R.	969 Madison Av., New York,	1891
McMichael, D. A.	67 W. 96th, New York,	1892
McMurray, Robert	234 Second Av., New York,	1871
Milbank, W. E.	111 State, Albany,	1879
Miller, John	48 St. John's Pl. Buffalo,	1891
Miller, R. E.	Oxford,	1871
Miner, W. S.	338 Alexander, New York,	1891
Minton, Henry	165 Joralemon, Brooklyn,	1864
Minton, Henry B.	165 Joralemon, Brooklyn,	1888
Mitchell, John J.	Newburgh,	1880
Moffat, John L.	17 Schermerhorn, Brooklyn,	1883
MOFFAT, R. C. (1885)	17 Schermerhorn, Brooklyn,	1863
Montanye, Wm. De La	Rondout, Kingston,	1891
Morgan, A. R.	105 E. 82d, New York,	1866

		Elected.
Moseley, Geo. T.	188 Franklin, Buffalo,	1891
Mossman, N. A.	350 Madison Av., New York,	1892
Mull, P. W.	Ghent,	1876
Muncie, E. H.	363 Tompkins Av., Brooklyn,	1890
Musits, Henry von.	1266 Lexington Av., New York,	1892
Nead, W. M.	210 State, Albany,	1891
Nickelson, Wm. H.	Adams,	1889
Noble, G. Z.	514 Penn Av., Elmira,	1864
Norton, Arthur B.	146 W. 34th, New York,	1886
Nott, Frederick J.	500 Madison Av., New York,	1891
Noxon, Mary Woolsey	28 W. 45th, New York,	1891
O'Connor, Mrs. Helen M. C.	18 W. 43d, New York,	1889
O'Connor, Joseph T.	18 W. 43d, New York,	1889
Osborne, Nehemiah	316 Summer, Buffalo,	1892
Ostrom, Homer I.	42 W. 48th, New York,	1886
Otis, Charles F.	Honeoye Falls,	1890
Otis, John C.	Poughkeepsie,	1883
Paige, H. Worthington	320 W. 28th, New York,	1892
PAINE, HENRY D. (1890)	Nutley, N. J.,	1863
PAINE, HORACE M. (1891)	105 State, Albany,	1864
Pardee, Ward C.	86 Monroe, Brooklyn,	1891
Partridge, Barton S.	East Bloomfield,	1889
Pearsall, John A.	Saratoga Springs,	1882
Pearsall, S. J.	128 W. 78th, New York,	1866
Pease, Charles G.	101 W. 72d, New York,	1891
Perrine, C. Willard	76 Clifton, Rochester,	1890
Pettit, Alonzo R.	Patchogue,	1891
Phillips, R. Oliver	Yonkers,	1891
Pierce, Willard Ide	64 W. 126th, New York,	1890
Pierron, Henry J.	438 Greene Ave., Brooklyn,	1890
Pierson, W. H.	101 McDonough, Brooklyn,	1891
Pitts, D. W.	315 16th, W. Troy,	1888
Porter, Eugene H.	181 W. 73d, New York,	1888
Powell, Lefferts M.	Chatham Centre,	1892
Pratt, Edwin J.	7 W. 39th, New York,	1888
PRATT, L. M. (1886)	104 State, Albany,	1864
Preston, H. G.	98 Lafayette Ave., Brooklyn,	1875
Pritchard, G. C.	Phelps,	1882
Proctor, John C.	89 Sophia, Rochester,	1888
Proctor, Willis H.	Binghamton,	1884

		Elected.
Purdy, Mark S.	Corning,	1887
Queen, Louis Apgar	492 W. 153d, New York,	1891
Rabe, F. E.	227 W. 42d, New York,	1892
Radway, C. W.	Mexico,	1885
Reynolds, W. U.	224 Second Ave., New York,	1888
Richardson, Andrew J.	39 E. 83d, New York.	1891
Richardson, G. W.	138 E. 79th, New York,	1891
Ritch, Amos M.	262 Stuyvesant Ave., Brook'n,	1892
Ritch, Orando S.	314 Macon, Brooklyn,	1889
Roberts, D. J.	New Rochelle,	1889
Roberts, G. W.	137 W. 34th, New York,	1891
Robinson, E. H.	176 Carlton, Toronto, Can.,	1892
Robinson, Nathaniel	"The Renaissance," Brooklyn,	1890
Robinson, R. W.	27 William, Auburn,	1889
Rockefeller, H. O.	181 Warwick, Brooklyn,	1892
Rogers, E. W.	Crystal Spring,	1879
Rounds, W. E.	154 W. 47th, New York,	1889
Rowley, Charles A.	Victor,	1890
Royal, T. Cook	Ballston Spa,	1888
Russell, H. Everett	57 E. 76th, New York,	1892
Russell, J. E.	1036 Bedford Ave., Brooklyn,	1889
Schenck, H. D.	241 McDonough, Brooklyn,	1887
Schley, J. Montfort	1 E. 42d, New York,	1889
Schumann, Carl	Delhi,	1892
Scott, Wm. H.	104 W. 44th, New York,	1888
Searle, W. S.	132 Henry, Brooklyn,	1865
Seegar, Ferdinand	718 Lexington Ave., New York,	1857
Seeley, W. W.		1886
Seymour, Abby Jeannette	791 The Front, Buffalo,	1891
Seward, Frederick W.	Goshen,	1891
Seymour, G. W.	Westfield,	1883
Shafer, Levi	Kingston,	1874
Shaw, J. C.	Hoosick Falls,	1885
Sheldon, Jay W.	402 Warren, Syracuse,	1885
Shelton, George G.	251 Madison Ave., New York,	1886
Shepard, George A.	146 W. 34th, New York,	1892
Shepard, Jessie	138 Delaware Ave, Buffalo,	1891
Sherman, Marcena E.	212 Lake Ave., Rochester,	1890
Simmons, Daniel	97 Lee Ave., Brooklyn,	1884
Simmons, Robert S.	129 E. 59th, New York,	1891

		Elected.
Simmons, Silas S	Susquehanna, Penn.,	1885
Skinner, Scott W	LeRoy,	1887
Slaught, J. E	Warsaw,	1883
Smith, Henry M	21 W. 24th, New York,	1885
Smith, Hugh M	78 Orange, Brooklyn,	1889
Smith, Oran W	Union Springs,	1884
Smith, St. Clair	8 W. 38th, New York,	1891
Smith, T. Franklin	264 Lenox Ave., New York,	1871
Snyder, E. E	Binghamton,	1883
Southwick, A. B	Rome,	1871
Southwick, D. E	Ogdensburgh,	1867
Spencer, Thomas D	19 S. Union, Rochester,	1884
Spoor, D. E	170 Lafayette, Schenectady,	1883
Spoor, F. W	North Granville,	1891
Stebbins, J. H	Geneva,	1871
Stewart, J. A	1032 Bedford Ave., Brooklyn,	1892
Stiles, Henry R	Hill View, Bolton,	1885
Stiles, S. E	51 Greene Ave., Brooklyn,	1880
Storer, J. H	30 Edgecomb Ave., New York,	1892
Strong, C. H	34 W. 32d, New York,	1892
Strunk, E. P	Brewster,	1891
Stumpf, D. B	631 Ellicott, Buffalo,	1885
Sumner, Charles R	31 S. Clinton, Rochester,	1882
Sweeting, Wm. H	Savannah,	1890
Swett, Emily F	Medina,	1892
Swift, Edward P	Pleasantville,	1888
Talcott, Selden H	Middletown,	1874
Teets, Charles E	217 W. 23d, New York,	1888
Terry, M. O	196 Genesee, Utica,	1876
Thompson, Virgil	137 W. 13th, New York,	1888
Throop, A. P	Port Gibson,	1874
Thurber, T. J	183 Plymouth Ave., Rochester,	1889
Townsend, Irving	66 W. 46th, New York,	1891
Trotter, Richard R	Yonkers,	1890
Tuttle, Edward G	66 W. 46th, New York,	1892
Tytler, George E	113 W. 126th, New York,	1889
Valentine, R. K	25 Eighth Ave., Brooklyn,	1891
Van Cleef, C. E	Ithaca,	1883
Van Denburg, M. W	Fort Edward,	1887
Vehslage, S. H	313 E. 18th, New York,	1891

		Elected.
Von der Lühe, Augustus, C. F.	245 Hooper, Brooklyn,	1883
Waldo, H. L.	1834 Fifth Ave., Troy,	1879
Walker, Catherine	180 Richmond Ave., Buffalo,	1886
Walker, Charles E	West Henrietta,	1887
Wallace, Wm. I	Montgomery,	1892
Walrad, C. B.	Johnstown,	1889
Walters, Chas. A	111 Milton, Brooklyn,	1890
Ward, C. A.	Binghamton,	1890
Warner, Alton G.	194 Schermerhorn, Brooklyn,	1888
WATSON, WILLIAM H. (1891)	270 Genesee, Utica,	1866
Weed, Robert M.	132 E. 45th, New York,	1892
Wellington, James F	12 Market, Corning,	1891
WELLS, LUCIEN B. (1887)	148 Park Ave., Utica,	1864
Wetmore, John McE	41 E. 29th, New York,	1892
White, A. Lenora	110 W. 44th, New York,	1892
White, J. C.	Portchester,	1891
White, J. Ralsey	1944 Madison Ave., New York,	1863
White, Sue A	221 Genesee, Utica,	1883
White, T. C	44 S. Clinton, Rochester,	1872
Whitney, E. J	100 Lafayette Ave., Brooklyn,	1875
Whiton, Alpha M	Brockport,	1891
Wilcox, DeWitt G	568 Delaware Ave., Buffalo,	1887
Wilcox, F. P	Clifton Springs,	1892
Wilcox, Sidney F	Broadway and 57th, New York,	1881
Williams, Frank B	583 Bedford Ave., Brooklyn,	1891
Williams, Frank Fay	6 Goodrich, Canton,	1892
Williams, T. C	28 W. 36th, New York,	1889
Williamson, A. P	Fergus Falls, Minn.,	1885
Willis, Harrison	695 Lafayette Ave., Brooklyn,	1877
Willis, H., Jr.	1303 Dean, Brooklyn,	1892
Winchell, Walter B	102 Sixth Ave., Brooklyn,	1889
Winterburn, George William	230 W. 132d, New York,	1885
Wolcott, E. H	96 East Ave., Rochester,	1886
Woodruff, Alden J	Babylon,	1891
Wright, A. R	166 Franklin, Buffalo,	1863
Zwetsch, J. D	Gowanda,	1883

DELEGATE MEMBERS.

(*Signifies also a permanent member.)

CLASS I.

Terms expire with the annual meeting in 1893.

Broome County, 1.—(Middle District.)
*Ward C. A., Binghamton.

Cayuga County, 2.—(Western District.)
Barnes, Chas. F., Weedsport.
Wakeley, W. A., Orange, N. J.

Chenango County, 1.—(Middle District.)
Spencer, H. J., West Winfield.

Columbia County, 1.—(Eastern District.)

Dutchess County, 2.—(Southern District.)

Livingston County, 1.—(Middle District.)
McKenzie, John A., Lima.

Monroe County, 3.—(Western District.)
Chamberlayne, Louise F., 127 East Av., Rochester
Doane, W. H., Pittsford.
Neefus, P. W., 103 East Av., Rochester.

Montgomery County, 1.—(Eastern District.)
*Walrad, C. B., Johnstown, Fulton County.

Oneida County, 2.—(Middle District.)
Kern, E. G., Herkimer.
Dean, L. W., Waterville.

Westchester County, 3.—(Southern District.)
*Phillips, R. Oliver, Yonkers.

CLASS II.

Terms expire with the annual meeting in 1894.

Jefferson County, 1.—(Middle District.)

Kings County, 18.—Brooklyn—(Southern District.)
Aten, W. H., 143 St. Felix.
Bierbauer, B. W., 109 Cumberland.
Bishop, Gertrude G., 475 Madison.
Breck, W. B., 64 Seventh Av.

Carr, H. L., 856 Lafayette Av.
Clarke, M. Elizabeth, 8 Lafayette Av.
Cort, Lottie A., 89 Division Av.
Grady, Mary E., 436 Monroe.
Hopper, Magnus T., 155 Hancock.
Hudson, W. T., 218 Livingston.
Hunt, Ida B., 214 Quincy.
Iler G. H., 455 Halsey.
Lassen, Helene S., 152 Henry.
Lawrence, Jerome B., 289 Ninth.
Rink, W. S., 272 Halsey.
Risley, F. E., 355 Jefferson Av.
Smith, Charles W., 255 Thirteenth.
Stewart, J. A., 1030 Bedford Av.

Madison County, 1.—(Middle District.)
Coon, E. N., DeRuyter.

Onondaga County, 3.—(Western District.)
Keeler, E. E., 414 S. Salina, Syracuse.
Sherwood, B. W., 1117 S. Salina, Syracuse.

Wayne County, 1.—(Western District.)

CLASS III.

Terms expire with the annual meeting in 1895.

Albany County, 4.—Albany—(Eastern District.)
Blessing, E. A., 93 Hudson Av.
Robinson, W. F., 214 State
Schwartz, C. W., 1 Clinton Sq.

Erie County, 6.—(Western District.)
Baethig, H., 350 Pennsylvania Av., Buffalo.
Frost, H. C., 212 Delaware Av., Buffalo.
Stearns, G. R., 205 Linwood Av., Buffalo.

Chemung County, 1.—(Middle District.)

Ontario County, 1.—(Western District.)
Mitchel C. T., Canandaigua.

Oswego County, 1.—(Middle District.)
Adams, G. F., Pulaski.
Hinman, E. L., 84 W. Oneida, Oswego.

Orange County, 2.—
Day, Geo. H., Monroe.
Ostrom, J. W., Goshen.

St. Lawrence County, 1.—(Eastern District.)

*Bell, W. N., 6 Greene, Ogdensburgh.

Seneca County, 1.—(Western District.)

*Follett, Wm. M., Seneca Falls.

Steuben County, 2.—(Middle District.)

CLASS IV.

Terms expire with the annual meeting in 1896.

New York County, 30.—(Southern District.)

Beyea, J. L., 217 Second Av.
Bryan, J. H., 375 Manhattan Av.
Cannon, Mott D., 167 W. 128th.
Carleton, E., 53 W. 45th.
Cossaart, A. B., 1421 Lexington Av.
Durrie, G. B., 37 W. 45th.
Dyer, Chas. L., 65 W. 36th.
Gerard, Louise, 149 W. 41st.
Guernsey, W. N., 27 W. 52d.
Hallett, G. D., 81 W. 87th.
Honan, W. F., 104 W. 64th.
Jones, Walter H., 202 W. 74th.
MacIvor, Abbie H., 2151 Seventh Av.
Macy Chas. S., 117 W. 12th.
McMichael, J. E., 23 E. 126th.
Oertel, G. F., 404 W. 22d.
Ogden, E. G., 451 West End Av.
Palmer, A. W., 101 W. 81st.
Palmer, Miles W., 235 E. 18th.
Pearsall, W. S., 128 W. 78th.
Sheldon, F. P., 237 W. 127th.
Sherman, L. B., 351 W. 14th.
Simonson, J. T., 61 E. 83d.
Talcott, W. S., 223 W. 125th.
Thompson, J. H., 36 E. 30th.
VerNooy, Chas., 148 W. 64th.
Waite, Phebe J. B., Ninth Av. & 34th.
White, W. Storm, 56 W. 48th.
Williams, Cordelia, 30 E. 22d.

DIRECTORY

OF THE

HOMŒOPATHIC PRACTITIONERS

OF THE

STATE OF NEW YORK.

DECEMBER, 1892.

Secretaries of County Societies in italics.
* Permanent Member of State Society.
† Delegate Member of State Society.
‡ Member of County Society.

The thanks of the Society are due (and are hereby acknowledged) to those few who have afforded aid in the compilation of this Directory. The list is still incomplete, numbering only 1187, and no one can deprecate its errors and shortcomings more than does the undersigned; all who notice any such will confer a favor upon the profession at large by promptly sending corrections and additions to

JOHN L. MOFFAT,
Secretary.

17 Schermerhorn Street,
Brooklyn, N. Y.

The Directory this year shows 1187 homœopathic doctors in 304 towns of 57 counties, distributed as follows:

‡Albany.....21	Herkimer..... 2	Richmond..... 4
Allegany..... 4	‡Jefferson..... 16	Rockland..... 2
‡Broome..... ..18	‡Kings.....203	‡St. Lawrence.. 18
Cattaraugus..... 5	Lewis..... 2	Saratoga..... 8
‡Cayuga.....16	‡Livingston.... 12	Schenectady.... 4
Chautauqua.....11	‡Madison..... 15	Schoharie..... 0
Chemung... 15	‡Monroe..... 66	Schuyler..... 3
‡Chenango..... 4	‡Montgomery.. 4	‡Seneca..... 9
Clinton..... 1	‡New York....322	Steuben..... 10
‡Columbia... ...11	Niagara..... 8	Suffolk..... 11
Cortland..... 8	‡Oneida..... 22	Sullivan..... 0
Delaware..... 4	‡Onondaga..... 31	Tioga..... 7
Dutchess..... 9	‡Ontario..... 18	Tompkins..... 10
‡Erie.....60	‡Orange..... 22	Ulster..... 12
Essex..... 8	Orleans..... 5	Warren..... 4
Franklin..... 1	‡Oswego..... 13	Washington.... 16
Fulton..... 6	Otsego..... 10	Wayne..... 21
Genesee..... 3	Putnam..... 2	‡Westchester.. 34
Greene..... 2	Queens..... 10	Wyoming..... 6
Hamilton..... 0	Rensselaer..... 20	Yates..... 4

‡County Society.

TOWN INDEX.

Town.	County.	Town.	County.
Adams,.....	..Jefferson	Batchellerville,.....	Saratoga
Albany,.....	Albany	Bath,.....	Steuben
Albion,.....	Orleans	Bay Shore,.....	Suffolk
Alexandria Bay,.....	Jefferson	Belfast,.....	Allegany
Amsterdam, ...	Montgomery	Big Flats,.....	Chemung
Athens,.....	Greene	Binghamton,.....	Broome
Attica,.....	Wyoming	Blythebourne,.....	Kings
Auburn,.....	...Cayuga	Bolton,.....	Warren
Avon,.....	Livingston	Boonville,.....	Oneida
Babylon,.....	Suffolk	Brewster,.....	Putnam
Baldwinsville,.....	Onondaga	Brier Hill,.....	St. Lawrence
Ballston Spa,.....	.. Saratoga	Brighton,.....	....Monroe
Batavia.....	Genesee	Brockport.....	Monroe

Town.	County.
Brooklyn,	Kings
Brownville,	Jefferson
Buffalo,	Erie
Caledonia,	Livingston
Cambridge,	Washington
Canandaigua,	Ontario
Canastota,	Madison
Candor,	Tioga
Canisteo,	Steuben
Canoga,	Seneca
Canton,	St. Lawrence
Cape Vincent,	Jefferson
Carthage,	Jefferson
Castleton,	Rensselaer
Catlin,	Chemung
Cazenovia,	Madison
Chatham,	Columbia
Chatham Centre,	Columbia
Chittenango,	Madison
Clifton Springs,	Ontario
Clinton,	Oneida
Clintondale,	Ulster
Clyde,	Wayne
Cohoes,	Albany
Colton,	St. Lawrence
Cooperstown,	Otsego
Corning,	Steuben
Cornwall,	Orange
Cortland,	Cortland
Crown Point,	Essex
Crystal Spring,	Yates
Dansville,	Livingston
De Kalb,	St. Lawrence
Delhi,	Delaware
De Ruyter,	Madison
Dobb's Ferry,	Westchester
Dunkirk,	Chautauqua
Eagle Bridge,	Rensselaer
East Aurora,	Erie
East Bloomfield,	Ontario
East Chatham,	Columbia
East Hamilton,	Madison
Easton,	Washington
Elbridge,	Onondaga
Elizabethtown,	Essex
Ellenville,	Ulster
Elmira,	Chemung
Essex,	Essex
Etna,	Tompkins
Exeter,	Otsego
Fairport,	Monroe
Farmer Village,	Seneca
Fayetteville,	Onondaga
Flatbush,	Kings
Flushing,	Queens
Fort Ann,	Washington
Fort Edward,	Washington
Fort Plain,	Montgomery
Franklin,	Delaware
Fredonia,	Chautauqua
Friendship,	Allegany
Fulton,	Oswego
Gasport,	Niagara
Geneseo,	Livingston
Geneva,	Ontario
Genoa,	Cayuga
Ghent,	Columbia
Glen Cove,	Queens
Glens Falls,	Warren
Gloversville,	Fulton
Goshen,	Orange
Gouverneur,	St. Lawrence
Gowanda,	Cattaraugus
Granville,	Washington
Greenbush,	Rensselaer
Greenport,	Suffolk
Greenwich,	Washington
Groton,	Tompkins
Hamilton,	Madison
Hammondsport,	Steuben

Town.	County.
Hartwick,	Otsego
Hempstead,	Queens
Herkimer,	Herkimer
Homer,	Cortland
Honeoye Falls,	Monroe
Hoosick,	Rensselaer
Hoosick Falls,	Rensselaer
Hornellsville,	Steuben
Horseheads,	Chemung
Hudson,	Columbia
Huntington,	Suffolk
Italy Hollow,	Yates
Ithaca,	Tompkins
Jamaica,	Queens
Jamestown,	Chautauqua
Johnsonville,	Rensselaer
Johnstown,	Fulton
Jordan,	Onondaga
Keeseville,	Essex
Kinderhook,	Columbia
Kingsboro,	Fulton
Kingston,	Ulster
Lansingburgh,	Rensselaer
Lebanon Springs,	Columbia
Le Roy,	Genesee
Lima,	Livingston
Little Falls,	Herkimer
Liverpool,	Onondaga
Livonia Station,	Livingston
Lockport,	Niagara
Logan,	Schuyler
Long Island City,	Queens
Lowville,	Lewis
Ludlowville,	Tompkins
Lysander,	Onondaga
Lyons,	Wayne
Madison,	Madison
Maine,	Broome
Malone,	Franklin
Mamaroneck,	Westchester
Mannsville,	Jefferson
Margaretville,	Delaware
Marion,	Wayne
Massena,	St. Lawrence
Mechanicville,	Saratoga
Mecklenburgh,	Schuyler
Medina,	Orleans
Medway,	Greene
Memphis,	Onondaga
Meridian,	Cayuga
Mexico,	Oswego
Middleport,	Niagara
Middletown,	Orange
Mineville,	Essex
Modena,	Ulster
Monroe,	Orange
Montgomery,	Orange
Moriah,	Essex
Moravia,	Cayuga
Morris,	Otsego
Morrisville,	Madison
Morton's Corners,	Erie
Mt. Kisko,	Westchester
Mt. Morris,	Livingston
Mt. Vernon,	Westchester
Naples,	Ontario
Nelsonville,	Westchester
Newark,	Wayne
Newark Valley,	Tioga
New Brighton,	Richmond
Newburgh,	Orange
New Paltz,	Ulster
New Rochelle,	Westchester
New Scotland,	Albany
New Utrecht,	Kings
New York,	New York
Niagara Falls,	Niagara
Niverville,	Columbia
North Granville,	Washington
North Tonawanda,	Niagara
North Tarrytown,	Westchester
Norwich,	Chenango

Town.	County.
Norwood,	St. Lawrence
Nunda,	Livingston
Nyack,	Rockland
Oak's Corners,	Ontario
Ogdensburgh,	St. Lawrence
Olean,	Cattaraugus
Oneida,	Madison
Oneonta,	Otsego
Ontario,	Wayne
Osborne Hollow,	Broome
Oswego,	Oswego
Otsego,	Otsego
Ovid,	Seneca
Owasco,	Cayuga
Owego,	Tioga
Oxford,	Chenango
Palermo,	Oswego
Palmyra,	Wayne
Patchogue,	Suffolk
Patterson,	Putnam
Peekskill,	Westchester
Penfield,	Monroe
Penn Yan,	Yates
Perry,	Wyoming
Phelps,	Ontario
Phœnix,	Oswego
Pittsford,	Monroe
Plainville,	Onondaga
Plattsburgh,	Clinton
Pleasantville,	Westchester
Port Byron,	Cayuga
Portchester,	Westchester
Port Gibson,	Ontario
Port Jervis,	Orange
Port Leyden,	Lewis
Tarrytown,	Westchester
Theresa,	Jefferson
Throopville,	Cayuga
Ticonderoga,	Essex
Tonawanda,	Erie
Tottenville,	Richmond
Potsdam,	St. Lawrence
Poughkeepsie,	Dutchess
Pulaski,	Oswego
Randolph,	Cattaraugus
Redwood,	Jefferson
Richfield Springs,	Otsego
Riverhead,	Suffolk
Rochester,	Monroe
Rome,	Oneida
Rush,	Monroe
Sandy Hill,	Washington
St. Clairville,	Chautauqua
Saratoga Springs,	Saratoga
Savannah,	Wayne
Schenectady,	Schenectady
Scott,	Cortland
Scottsville,	Monroe
Seeley Creek,	Chemung
Seneca Falls,	Seneca
Sherburne,	Chenango
Shortsville,	Ontario
Shrub Oak,	Westchester
Silver Creek,	Chautauqua
Sing Sing,	Westchester
Skaneateles,	Onondaga
Slate Hill,	Orange
Sodus,	Wayne
South Butler,	Wayne
South Greece,	Monroe
Southold,	Suffolk
Springwater,	Livingston
Stanfordville,	Dutchess
Stockholm Depot,	St. Lawrence
Stone Ridge,	Ulster
Syracuse,	Onondaga
Trenton,	Oneida
Troy,	Rensselaer
Trumansburg,	Tompkins
Tully,	Onondaga
Unadilla,	Otsego
Union,	Broome

Town.	County.
Union Springs,	Cayuga
Utica,	Oneida
Victor,	Ontario
Walden,	Orange
Walton,	Delaware
Walworth,	Wayne
Warner's Station,	Onondaga
Warsaw,	Wyoming
Warwick,	Orange
Waterford,	Saratoga
Waterloo,	Seneca
Watertown,	Jefferson
Waterville,	Oneida
Watkins,	Schuyler
Waverly,	Tioga
Wayland,	Steuben
Weedsport,	Cayuga
Wellsville,	Allegany
Westbury Station,	Queens
Westfield,	Chautauqua
West Eaton,	Madison
West Henrietta,	Monroe
West New Brighton,	Richmond
West Troy,	Albany
West Winfield,	Chenango
White Creek,	Washington
Whitehall,	Washington
White Plains,	Westchester
Williamson,	Wayne
Williamstown,	Oswego
Winthrop,	St. Lawrence
Woodhaven,	Queens
Wyoming,	Wyoming
Yonkers,	Westchester

ALBANY COUNTY.

ALBANY.

†‡Blessing, Elmer A., 93 Hudson Avenue.
*‡Carroll, Stephen H., 228 State.
Cox, Frederick J., 109 State.
*‡Cox, Geo. A., 80 S. Swan.
*‡Cox, Jas. W., 109 State.
*‡Gorham, Geo. E., 160 Hamilton.
*‡Hunting, Nelson, 155 Hamilton.
*‡Jones, Chas. E., 140 State.
*‡Jones, E. Darwin, 140 State.
*‡Milbank, W. E., 111 State.
*‡Nead, W. M., 210 State.
*‡Paine, Horace M., 105 State.
Paine, Howard S., 105 State.
*‡Pratt, Lester M., 123 N. Pearl.
†‡*Robinson. W. F.*, 59 Washington Avenue.
†‡Schwartz, Chas. W., 81 Clinton Avenue.

COHOES.

*‡Billings, Geo. H.
Campbell, Wm. M.

NEW SCOTLAND.

‡Fitch, J. H.

WEST TROY.

*Pitts, D. W., 315 Sixteenth.
Van Alstyne, Frank W.

ALLEGANY COUNTY.

ALFRED CENTER.

Truman, I. P.

BELMONT.

Hardy, ———

BELFAST.

*Chamberlain, J. H.

CUBA.

Gillette, ———

FRIENDSHIP.

Wellman, W. I.

Williamson, B. F.

WELLSVILLE.

Gish, C. L.

BROOME COUNTY.

BINGHAMTON.

‡*Bailey, D. P.*, 41 Court.
*‡Corwin, Elizabeth, 104 Main.
‡Dildine, Ida L., 5 Main.
‡Fiske, Mrs. Katrina C., 314 Chenango.
*‡Haines, Chas. T., 27 Main.
*‡Hand, Geo. F., 75 Court.
Jenkins, Geo. H., 139 Main.
*‡Martin, Lynn A., 91 Collier.
‡McGraw, De Witt H., 3 and 4 Hugaman Block.
‡Mills, Mrs. Alice F., 19 Main.
*‡Proctor, Willis H., 8 Main.
‡Sloan, Henry S., 1 Exchange Pl.
*‡Snyder, E. E., 27 Main.
*‡Ward, Charles A., 35 Court.
Winters, C., 122 Court.

MAINE.

*‡Guy, Clement N.

OSBORNE HOLLOW.

‡Adams, C. Wilson.

UNION.

*‡Knapp, Theodore P.

CATTARAUGUS COUNTY.

OLEAN.

Steyner, J. F.
Steyner, Mrs. J. F.
Hibbard, D. V. M.
Richards, ———

RANDOLPH.

Whipple, ———

CAYUGA COUNTY.

AUBURN.

‡Boyce, C. W., 19 South.
*‡Frye, M. M., 167 Genesee.
‡Gwynn, Chas. A., 3 William.
‡Hyatt, F. M. 49 E. Genesee.
*‡Robinson, Robt. W., 27 William.
Smith, Truman K., 173 Genesee.
‡*Swift, Chas. L.*, 279 Seymour.

GENOA.

Skinner, ———

MERIDIAN.

Bartlett, ———

MORAVIA.

‡Cook, W. C.

OWASCO.

‡Curtis, W. H.

PORT BYRON.

‡Crissy, W. A.

THROOPVILLE.

‡Gwynne, W. M.

UNION SPRINGS.

‡Alleman, ——— *Smith, Oran W.

WEEDSPORT.

††Barnes, C. F.

CHAUTAUQUA COUNTY.

DUNKIRK.

*Alling, D. G., 29 W. 4th, Blackham, ———

FREDONIA.

*Couch, Asa S. Dods, A. Wilson.

JAMESTOWN.

Ormes, F. D. Ward, ———
Scott, ——— Wright, W. B.

ST. CLAIRVILLE.

Curtis, F. L.

SILVER CREEK.

Noble, W. A.

WESTFIELD.

*Seymour, G. W.

CHEMUNG COUNTY.

BIG FLATS.

‡Davis, D. L.

CATLIN.

‡Thorn, Sarah Eddy.

ELMIRA.

*‡Adriance, F. W., 306 Lake. ‡Jenks, R. B.
Campbell, C. E. ‡Mills, R. N.
Easton, J. D. ‡Morse, B. W.
*‡Eddy, Ermina C., 500 William. Noble, E. H., 514 Penn. Av.
Ingham, Geo. W. *Noble, G. Z., 514 Penn. Av.
‡Parkhurst, L. D.

HORSEHEADS.

‡Groom, O.

SEELEY CREEK.

‡Robbins, A. F.

CHENANGO COUNTY.

NORWICH.

‡*Fulton, Samuel J.*

OXFORD.

*‡Miller, R. E.

SHERBURNE.

‡Owen, Ira C.

WEST WINFIELD.

†‡Spencer, H. J.

CLINTON COUNTY.

*Low, Elliot C., Oak, cor. Brinkerhoff.

GREENE.

No physician—good opening.

NEW BERLIN.

No physician—good opening.

COLUMBIA COUNTY.

(Columbia and Greene Counties Society.)

CHATHAM.

*‡Barnes, W. H.

Van Buren, Hattie C.

CHATHAM CENTRE.

*‡Powell, L. M.

EAST CHATHAM.

Van Buren, B. L. (Lic.)

GHENT.

‡Green, J. H.

*‡Mull, P. W.

HUDSON.

*‡Cook, C. P.

‡Tracy, A. M.

KINDERHOOK.

‡Green, James

LEBANON SPRINGS.

Sanford, Wilbur F.

NIVERVILLE.

‡Mesick, John C.

CORTLAND COUNTY.

CORTLAND.

Ball, Jay

Nash, E. B.

Johnson, H. P.

Santee, E. M.

Spalding, Julia H.

HOMER.

Goodelle, R. A.
Potter, Leman W.

SCOTT.

Babcock, S. H.

DELAWARE COUNTY.

DELHI.

*Schumann, Carl

FRANKLIN.

Foote, J. H.

MARGARETVILLE.

Telford, John W.

WALTON.

Leonard, H. K.

DUTCHESS COUNTY.

(County Society Moribund.)

POUGHKEEPSIE.

Bruyn, Richard V.
*Case, Walter R., 239 Mill.
*Faust, Fred A., 16 Garden.
*Lane, Chas. E., 280 Mill.
McIntosh, S. D., 10 Garden.
*Otis, John C.
Otis, J. H.

STANFORDVILLE.

Angell, Augustus
Angell, Milton H.

ERIE COUNTY.

BUFFALO.

*Albertson, Chas. S., 358 Richmond Ave.
Babcock, C. W., 151 Allen.
†‡Baethig, Henry, 350 Pennsylvania Ave.
‡Beals, Herbert J., 160 Franklin.
Bodenbender, Nelson J., 804 Jefferson.
Bourne, P. H., Hom. Hospital.
*Brayton S. N., 202 Delaware Ave.
Broardt, Peter, 394 Adams.
Buck Champlin, F., 362 Main.
‡Bull Alex, T., 184 Franklin.
*‡Bull, L. A., 160 Franklin.
Carter, P. L., 1122 West Av.
*‡Colton, Henry E., 362 Pearl.
*‡Cook, Joseph T., 138 Delaware Ave.
*‡Curtis, Alex M., 309 Elmwood Ave.
Dean, David A., 1233 Michigan.
Eadie, A. B., 99 Plymouth Ave.
*‡Erb, Peter., 109 Genesee.
*Fisher, E. A., 1039 Fillmore Ave.
*‡Foster, Hubbard A., 3 St. John's Pl.

†‡Frost, H. C., 212 Delaware Ave.
*‡Hadley, W. A. M., 188 Franklin.
*‡Halbert, J. Sanford., 389 Pearl.
*‡Heineman, John D., 77 Eagle.
‡Hinkley, A. S., 78 W. Huron.
Howard, C. F., 1458 Main.
‡Hussey, Elisha P., 493 Porter Ave.
*‡Kenyon, W. B., 86 W. Mohowk
*‡Lewis, F. Park, 188 Franklin.
‡Lewis, G. W., 311 Delaware Ave.
‡Lewis, G. W., Jr., 311 Delaware Ave.
Linquist, M. F., Homœopathic Hospital.
Long, Wm. E., 45 Breckenridge.
*‡McCrea, Philip A., 362 Main.
‡McGill, W. D., 294 S. Division.
*Martin, Truman J., 143 Bryant.
‡Maycock, Burt J., 166 Franklin.
*Miller, John 127 College.
‡Morris, Sarah H., 159 Franklin.
*‡Moseley, G. T., 202 Delaware Ave.
*‡Osborne, Nehemiah, 316 Summer
‡Parmenter, W. L., 931 Prospect Ave.
‡Petsch, C. F., 333 Genesee.
‡Pohle, J. D. A., 759 Michigan
Root, Reuben M. 537 Main.
Schladermundt, C. A., 332 S. Division.
*‡Seymour, Abby J., 791 Front Ave.
*‡*Shepard, Jessie*, 138 Delaware Ave.
†‡Stearns, G. R., 201 Linwood Ave.
Strong, C. E., R. R. Hospital.
*‡Stumpf, Daniel B., 631 Ellicott
‡Wage, John F., 418 Seneca.
*Walker, Catharine, 910 Delaware Ave.
*Wilcox, Dewitt G., 568 Delaware Ave.
Wilder, Rose C., 75 Niagara.
*‡Wright, A. R., 166 Franklin.

TONAWANDA.

Allen, Wm. L.
Simson, John R.

MORTON'S CORNERS.

Caulkins, F.

EAST AURORA.

Mitchell, ———

ESSEX COUNTY.

CROWN POINT.

Eaton, Erwin R.

ELIZABETHTOWN.

Wasson, T. A.

ESSEX.

Chase, Edwin R.

KEESEVILLE.

Severance, Karl
Pope, Willis G.

MINERVILLE.

Severance, B. W.

MORIAH.

Powell, George W.

TICONDEROGA.

Bond, George W.

FRANKLIN COUNTY.

MALONE.

Belding, D. R.

FULTON COUNTY.

(Montgomery County Society).

GLOVERSVILLE.

Bissell, D. A.
‡Eisenbrey, E. H.
*‡Garnsey, W. S., 77 N. Main.
Tuck, Arthur E.

JOHNSTOWN.

*‡Walrad, C. B.

KINGSBORO.

‡Ingalls, Gilbert.

GENESEE COUNTY.

BATAVIA.

*Hutchins, H. S., 215 E. Main.
*LeSeur, J. W., 215 E. Main.

LE ROY.

*Skinner, Scott W., 12 Myrtle.

GREENE COUNTY.

(Columbia and Greene Counties Society).

ATHENS.

‡Calkins, S. E.

MEDWAY.

‡Collins, D. E.

HAMILTON COUNTY.

(No Homœopathist).

HERKIMER COUNTY.

(Oneida County Society).

HERKIMER.

††Kern, E. G.

LITTLE FALLS.

*‡Brainard, L. L., 2 Cronkhite Block.

JEFFERSON COUNTY.

ADAMS.

*‡Nickelson, W. H.

ALEXANDRIA BAY.

Campbell, E. E.

‡Cole, J. D.

BROWNVILLE.

‡*Gates, R. F.*

CAPE VINCENT.

Bushnell, H. N.

CARTHAGE.

‡Simonds, C. A.

‡Simonds, E. A.

MANNSVILLE.

‡Hibbard, G. C.

REDWOOD.

‡Ryan, J. E.

THERESA.

‡Santway, F. L.

WATERTOWN.

‡Adams, M. M.
‡Farmer, G. S.
‡Gifford, G. A.
Knickerbocker, H. de L.
*‡Laird, W. T.
Smith, G. W. B.

KINGS COUNTY.

BLYTHEBOURNE.

*‡Hadley, C. H., 58th St., cor. 13th Ave.

FLATBUSH.

*Boocock, Robert

BROOKLYN.

Ashwin, Edward H., 125 Milton.
††Aten, Wm. H., 143 St. Felix.
*‡Atwood, J. Freeman, 149 Greene Ave.
*‡Avery, E. W., 16 Hancock.
*‡Baker, Jennie v. H., 512 Bedford Ave.
*‡Barkeloo, Harriet, 915 Third Ave.
*‡Baylies, B. L'B, 418 Putman Ave.
Beach, Arthur, 300 Sumner Ave.
*‡Bennet, G. H. R., 21 S. Portland Ave.
‡Bennett, N. K., 624 Macon.
††Bierbauer, B. W., Bkn. Hom. Hospital.
Birdsall, A. H., 1036 Bedford Ave.
††Bishop, Gertrude G., 475 Madison.
Blackman, Mrs. Lora, 519 Clinton Ave.
*‡Blackman, W. W., 519 Clinton Ave.

*Bleecker, Wm. H., 240 Van Sicklen Ave.
*‡Bolan L. W., 679 Greene Ave.
Bond, Frank, 27 Schermerhorn.
*‡Bonnell, Chas. L., 3 Hanson Pl.
†‡Breck, Wm. B., 64 Seventh Ave.
‡Brinckerhoff, A. S., 544 Monroe.
‡Bronson, Chas. H., 438 Pacific.
Broughton, L. D., Jr., 289 Ryerson.
Brown, Annie M., 976 Bedford Ave.
Bryant, Melville, 54 Greene Ave.
Bryant, W. C., 64 Greene Ave.
*‡Bulmer, Geo. W., 1210 Bushwick Ave.
‡Burnette, Katherine D., 486 Bedford Ave.
*‡Burnham, Clark, 182 Clinton.
*‡Butler, W. M., 507 Clinton Ave.
*‡Caldwell, Frank E., 151 Henry.
Campbell, Alice B., 114 S. Third.
‡Cardozo, Jacob L., 287 Hoyt.
Cargill, F. A., 507 McDonough.
†‡Carr, H. L., 856 Lafayette Ave.
*‡Cassidy, Georgia A., 703 Nostrand Ave.
*‡Chapin, Edward, 21 Schermerhorn.
‡Chaplain, F. T., 324 Sumner Ave.
Clark, F. G., 507 Decatur.
‡Clark, Homer, 343 Jefferson Ave.
†‡Clarke, M. Elizabeth, 8 Lafayette Ave.
‡Close, Stuart, 641 Willoughby Ave.
*‡Cornell, Geo. B., 192 A Sixth Ave.
†‡Cort, Lottie A., 89 Division Ave.
Denslow, N. H. 174 Keap.
‡Denison, R. N., 170 Sixth Ave.
Dewey, Geo. A., 239 Quincy.
Dickie, Perry, 200 Schermerhorn.
*‡Diehl, W., Jr., 36 McKibben.
*‡Doty, Geo. H., 129 Schermerhorn.
Dunlevy, D. C. B., 166 De Kalb Ave.
Dunlevy, Mrs., 65 Livingston.
‡Eaton, J. Albro, 94 Taylor.
*‡Eden, Sam'l., 1340 Bushwick Ave.
*‡Elliot, Amos H., 482 Quincy.
*‡Elliot, J. B., 493 Clinton Ave.
‡Ensey, M. W., Hom. Hospital.
Ermentraut, Henry, 466 Hart.
Fawdray, J. W., 48 Concord.
‡Fincke, Bernhard, 122 Livingston.
*‡Fiske, W. M. L., 484 Bedford Ave.
Forbes, J. Harrison, 195 Penn.
‡Gerau, Fr., 957 Willoughby Ave.
*Gillespie, Lizzie Safford, Bedford Ave. and S. Fifth.
‡Given, James B., 315, 11th.
*‡Gorton, D. A., 137 Clinton.
†‡Grady, Mary E., 436 Monroe.
Hamilton, C. T., 375 Degraw.
Hanford, Maria U., 178 S. Fifth.
Hanford, S. C., 178 S. Fifth.
Hanford, W. H., 84 Lee Ave.
Hanford, W. J., 432 Putnam Ave.
*‡Hasbrouck, Everitt, 369 Ninth.
Hawley, H. R., 30 Willow Place.
Hein, Max F., 405 Grand Ave.
Hobby, Ada T., 409 Lafayette Ave.
Hoffman, Henry, 246 Ninth.

††Hopper, M. T., 155 Hancock.
*Houghton, B. L., 1395 Bedford Ave.
††Hudson, W. T., 218 Livingston.
††Hunt, Ida B., 214 Quincy.
††Iler, G. H., 455 Halsey.
Jarrett, A. R., 91 Halsey.
*‡Jeffery, G. C., 343 Jefferson Ave.
*‡Jenks, F. Percy, 419 Ninth.
*‡Johnston, C. L., 467 Vanderbilt Ave.
*‡Kastendieck, J. T. W., 461 Bedford Ave.
Keep, J. Lester, 460 Clinton Ave.
‡Knapp, H. J., 68 Maujer.
††Lassen, Helene S., 152 Henry.
*‡Latimer, W. C., 410½ Clinton.
*‡Lauer, Chas. F., 241 Schenck.
††Lawrence, J. B., 289 Ninth.
Lewis, Elizabeth F., 370 Putnam Ave.
*‡Lewis, Henry M., 171 Remsen.
Lines, Mrs. Amelia W., 344 Washington Ave.
‡Lines, Mary L., 344 Washington Ave.
Lines, Oliver T., 344 Washington Ave.
Long, Laurie M., 207 Bedford Ave.
‡Lutze, F. H., 232 Ross.
Mandeville, D. K. 15 Fourth Ave.
‡Martin, Ella M., 453 Pacific.
‡Martineau, S. Catherine, 309 Clinton.
Martino, R. R., 139 New Jersey Ave.
‡McCune, Olive F., 53 Orange.
*‡McKinney, Susan S., 205 De Kalb Ave.
‡McLenathan, W. H., 101 Division Ave.
Mead, Byron E., 443 Pacific.
Metcalf, J. W., 609 Halsey.
‡Miner, Edwin, 410 Grand Ave.
*‡Minton, Henry, 65 Joralemon.
*‡Minton, Henry B., 165 Joralemon.
Mirrielees, Geo. J., 417 Putnam Ave.
*‡Moffat, John L., 17 Schermerhorn.
*‡Moffat, R. C., 17 Schermerhorn.
Monmonier, J. L., 128 Greene Ave.
‡Moriarty, Pierre C., 461 Halsey.
*‡Muncie, E. H., 363 Tompkins Ave.
Muncie, Mrs. L. H., 363 Tompkins Ave.
Nall, Chas. J., 364 State.
Newcomb, Geo. W., 191 Adelphi.
‡Nichols, Geo., 306 Monroe.
Nichols, G. H., 237 Leonard.
Nicholson, A. S., 836 Bedford Ave.
Nickerson, Fannie R., 16 Ormond Place.
‡Onderdonk, Emma, 104 S. Elliott Place.
‡Palmer, A. J., 90 Hancock.
‡Palmer, G. H., 90 Hancock.
Palmer, Warren B., 360 Hancock.
*‡Pardee, Ward C., 86 Monroe.
‡Parkhurst, G. H., 768 A Quincy.
Patterson, Phebe C., 260 Rutledge.
Patton, Jas. H., 26 Hanover Pl.
Phillips, Juan B. C., 9 Palmetto.
*‡Pierron, H. J., 438 Greene Ave.

Pierson, W. B., 162 Macon.
*‡Pierson, W. H., 101 McDonough.
*‡Preston, H. G, 98 Lafayette Ave.
Rankine, Isabella M., 626 Willoughby Ave.
Read, Georgianna D., 200 S. Oxford.
‡Richardson, B. M., 160 Halsey.
‡Richter, H. W., 240 Clinton.
†‡*Rink, Walter S.*, 272 Halsey.
†‡Risley, Frank E., 355 Jefferson Ave.
*Ritch, A. M., 262 Stuyvesant Ave.
*‡Ritch, Orando S., 314 Macon.
*‡Robinson, Nathaniel, Nostrand Ave. and Hancock.
‡Rockefeller, H. O., 181 Warwick.
*‡Russell, J. E., 1032 Bedford Ave.
‡Sage, H. P., Hom. Hospital.
*‡Schenck, H. D., 241 McDonough.
‡Schlegel, Louise, 129 Sumner Ave.
Schlick, C. G., 68 Maujer.
*‡Searle, W. S., 132 Henry.
Shattuck, H. P., 931 Gates Ave.
‡Shrewsbury, W. J., 270 S. Fifth.
*‡Simmons, D., 97 Lee Ave.
Slade, Harold, 316 Jefferson Ave.
‡Slee, H. C., 235 S. Fourth.
‡Smith, A. T., 699 Greene Ave.
†‡Smith, Chas. W., 255 Thirteenth.
‡Smith, Clara Louise, 808 Prospect Pl.
‡Smith, G. H., 921 Greene Ave.
*‡Smith, Hugh M., 78 Orange.
*‡Smith, Sidney E., 77 Arlington Ave.
‡Spooner, E. H., 590 McDonough.
Stafford, Fred E., 142 A Putnam Ave.
*‡Stewart, J. A., 1030 Bedford Ave.
*Stiles, S. E., 51 Greene Ave.
‡Stolz, Rosalie H., 490 Van Buren.
Straley, May W., 195 Hopkinson Ave.
‡Street, H. E., 98 Brooklyn Ave.
‡Sutton, John J., 91 Tompkins Ave.
Talmage, John F., 155 Joralemon.
‡Talmage, Samuel, 22 Schermerhorn.
Thayer, W. Irving, (Lic. K. Co. Soc.) 17 Brooklyn Ave.
‡Thompson, J. M., 382 Clinton.
*‡Valentine, R. K., 25 Eighth Ave.
Van Arnam, Mrs. A. B., 426 Franklin Ave.
Van Mater, G. G., 354 Macon.
Van Schoonhoven, C. S., 1060 Lafayette Ave.
Van Time, Margaret H., 60 Ft. Greene Pl.
Von der Lühe, Amelia, D. F., 801 Driggs.
*‡Von der Lühe, Angustus, 245 Hooper.
‡Von der Lühe, Margarethe B., 801 Driggs.
*Walters, Chas. A., 111 Milton.
Walters, John B., 114 Nassau Ave.
Wamsley, W. E., 255 Carlton Ave.
*‡Warner, Alton G., 194 Schermerhorn.
‡Watson, J. L., 257 Schermerhorn.

‡Wemmell, A. A. (Lic. N. Y. Eclectic Soc.) 2600 Atlantic Ave.
Whitehead, I. P., 562 Quincy.
*‡Whitney, E. J., 100 Lafayette Ave.
*‡Williams, F. B., 583 Bedford Ave.
Willis, Clinton, Hom. Hospital.
*‡Willis, Harrison, 695 Lafayette Ave.
*Willis, H. Jr., 1303 Dean.
‡Wilson, Chas. H., 97 Clymer.
*‡Winchell, W. B., 102 Sixth Ave.
Young, John, 240½ Rodney.
Zimmerman, Chas., Essex near Belmont.

NEW UTRECHT.

‡Robert, John C.

LEWIS COUNTY.

(‡Member of Jefferson County Society.)

LOWVILLE.

‡Bronson, Miles H.

PORT LEYDEN.

Ash, ———

LIVINGSTON COUNTY.

AVON.

‡Hermance, S. G.

CALEDONIA.

*‡Borden, G. T.

DANSVILLE.

‡*Andrews, B. P.*

GENESEO.

Norton, A. E.
Southall, E. W.
‡West, James A.

LIMA.

†‡McKenzie, John A.

LIVONIA STATION.

‡Bettis, J. T.

NUNDA.

‡Hammond, T. A.
‡Ostrander, P. M.

SPRINGWATER.

‡Whitfield, H. A.

MADISON COUNTY.

CANASTOTA.

‡Bartholomew, W. L.
‡Edgerton, M. G.

CAZENOVIA.

‡Bass, E. C.

CHITTENANGO.

*‡Deuel, W. E.

DE RUYTER.

††Coon, E. N.

EAST HAMILTON.

‡Palmer, G. B.

HAMILTON.

*‡Gifford, G. L.

Flint, C. B.

MADISON.

‡Gifford, Barton R.

MORRISVILLE.

Bresee, Charles H.

ONEIDA.

‡Loomis, Edward

‡Wallace, A. E.

Reynolds, Mrs. M. J.

‡ *Wallace, J. T.*

WEST EATON.

Burnham, Fred.

MONROE COUNTY.

BRIGHTON.

‡Doane, G. A.

‡Wheeler, J. P.

BROCKPORT.

*Whiton, Alpha M.

Winne, F. A.

FAIRPORT.

*‡Clapp, W. F.

‡Tubbs, J. F.

HONEOYE FALLS.

*Otis, Chas. F.

PENFIELD.

‡Humphreys, N. M.

PITTSFORD.

‡Doane, W. H.

Johnson, W. W.

ROCHESTER.

*‡Adams, Myron H., 46 North Fitzhugh.

‡Adams, R. A., 46 N. Fitzhugh.

Bachman, G. A., Hom. Hospital.

Baker, W. N., 77 Chestnut.

Bamber, O. Stewart, 75 Rowe.

Biegler, J. A., 58 S. Clinton.

Bennett, D. G., 52 S. Clinton.

*‡Bissell, E. J., 75 S. Fitzhugh.

Brownell, U. G., 122 North.

*‡Buell, Jesse W., 41 S. Clinton.
‡Carman, W. B., 302 University Ave.
Carr, Allen B., 89 N. Clinton.
†‡Chamberlayne, Mrs. Louise F., 127 East Ave.
*Collins, N. M., 43 East Ave.
‡Cox, J. T., 19 Clinton Pl.
*‡Dayfoot, H. M., 41 Sophia.
‡Earle, E. W., 55 Monroe Ave.
*‡Fowler, W. P., 63 S. Clinton.
*‡Graham, M. E., 10 Jones Ave.
Grant, R. C., 167 South Ave.
‡Hawley, L. B., 367 Jay.
‡Hayward, E. S., Hayward Ave.
*‡Haywood, G. M., 612 West Ave.
*‡Haywood, Julia F., 612 West Ave.
Hermance, A. C., 611 N. St. Paul.
Hoard, V. A., 11 N. Washington.
‡*Hoyt, Herbert W.*, 421 Monroe Ave.
‡Hoyt, Mrs. Mary M., 421 Monroe Ave.
*‡Keegan, W. A., 52 S. Clinton.
*‡Kellogg, C. M., 38 N. Clinton.
‡Leach, A. E., 11 Phelps Ave.
*‡Lee, J. M., 89 Plymouth Ave.
*‡Lee, Sarah I., 89 Plymouth Ave.
‡Lehman, F. F., 80 S. Clinton.
Lyman, J. Grant, 43 East Ave.
*MacCallum, Jno. H., 143 Childs.
†‡Neefus, P. W., 103 East Ave.
*‡Perrine, C. W., 135 Jefferson Ave.
*Proctor, J. C., 89 Sophia.
‡Rambo, W. S., 41 Sophia.
Ross, E. V., 279 Jefferson Ave.
Schmitt, J. G., 113 North.
*‡Sherman, Marcena E., 212 Lake Ave.
‡Snow, S. R., 342 Monroe Ave.
*‡Spencer, T. D., 19 S. Union.
‡Stillwell, F. W., 32 University Ave.
*‡Sumner, C. R., 31 S. Clinton.
*‡Thurber, T. J., 183 Plymouth Ave.
‡Tretton, J. K., 239 Lake Ave.
‡Van Allan, R. A., 232 Monroe Ave.
*‡White, T. C., 44 S. Clinton.
*‡Wolcott, E. H., 96 East Ave.

RUSH.

‡Lockwood, B. F.

SCOTTSVILLE.

‡Canfield, Charles A.

SOUTH GREECE.

‡Buell, E. S.

WEST HENRIETTA.

*‡Walker, C. E.

MONTGOMERY COUNTY.

AMSTERDAM.

*‡Frazier, L. A., 124 Division.
Hicks, H. M.
‡ *White, Wm. M.*, 26 Pearl.

FORT PLAIN.

‡Zoller, Wm.

NEW YORK COUNTY AND CITY.

Ackerman, C. W., 204 W. 133d.
‡Allen, Emma T. P., 213 W 54th
Allen, Gertrude M., 213 W. 54th.
*‡Allen, Paul, 10 E. 36th.
*‡Allen, T. F., 10 E. 36th.
‡Andrew, R. M., 2024 Lexington Ave.
‡Arcularius, P. E., 104 W. 44th.
‡Arschagouni, John, 155 Worth.
Bagg, C. L., 67 W. 45th.
Baker, C. M., 143 W. 4th.
‡Baldwin, J. G., 8 E. 41st.
Baldwin, Mary H., 274 Third Ave.
*‡Ball, A. S. (not practicing), 56 W. 53d.
*‡Ball, Halsey J., 126 W. 129th.
Bardwell, F. A., Flower Hospital.
‡Barnett, Amelia, 261 W. 23d.
Baruch, E., 57 E. 77th.
Baruch, S., 109 Second Ave.
Bassett, J. S., 11 W. 30th.
*‡Beebe, C. E., 15 E. 38th.
‡Benedix, R. F. W., 69 E. 1st.
‡Bennett, J. A., 117 W. 11th.
*‡Berghaus, A., 138 E. 65th.
†‡Beyea, J. L., 217 Second Ave.
‡Bigelow, A. J., 163 E. 106th.
‡Bigelow, F. A., 124 E. 23d.
‡Bishop, W. H., 465 Lexington Ave.
‡Bissell, Sarah E., 51 E. 20th.
‡Bond Mary E., 122 Lexington Ave.
Bowker, C. H., Ward's Island.
*‡Boyle, C. C., 6 E. 34th.
*‡Boynton, F. H., 34 W. 32d.
Brinck, W., 41 W. 19th.
*‡Brinkman, Mrs. M. A., 219 W. 23d.
‡Brown, G. C., 56 W. 45th.
*‡Brown, M. Belle, 135 W. 34th.
†‡Bryan, J. H., 375 Manhattan Ave.
*†Buchholz, Louise Z., 99 E. 7th.
*Burdick, Mrs. Alice H., 347 W. 34th.
‡Calisch, A. C., 155 North.
Campbell, Annie S., 162 W. 130th.
‡Campbell, C. E., 314 E. 18th.
†‡Cannon, M. D., 167 W. 128th.
*‡Carleton, B. G., 173 W. 47th.
†‡Carleton, E. 53 W. 45th.
‡Chapman, A. E., 234 W. 43d.
*‡Chase, J. O., 214 E. 53d.
Church, C. H., Ward's Island.
*‡Clark, B. G., 162 W. 122d.
*‡Cook, Mrs. H. N. F., 250 W. 22d.
Cook, Wm. H., 258 W. 23d.
*‡Cornell, C. W., 354 W. 58th.
†‡Cossaart, A. B., 1421 Lexington Ave.
Crompton, Chas. W., 321 E. 69th.
Cushing, Mrs. S. J., 322 W. 23d.
‡Dale, Marian A., 251 W. 122d.
Dana, Mrs. E. D. L., 107 W. 105th.
*‡Danforth, L. L. 35 W. 51st.
Daniels, J. L., 51 W. 127th.
*‡Davis, J. E. L., 34 E. 39th.
Day, L. A. L., 201 E. 23d.
*‡Deady, Chas., 110 W. 48th.
*‡Dearborn, H. M. 152 W. 57th.
‡Delabarre, W. E., 44 W. 22d.
*‡Demarest, J. H., 1969 Madison Ave.
*‡Deschere, M. 334 W. 58th.
Deyo, J. T., 143 E. 117th.

*‡Dillingham, T. M., 46 W. 36th.
*‡Dillow, Geo. M., 102 W. 43d.
‡Donaldson,S. J.,72 Madison Ave.
*‡Doughty, F. E., 512 Madison Ave.
*‡Dowe, F. Le C., Decatur Ave., Bedford Pk.
*‡Dowling, J. W., 41 W. 45th.
Drescher, L., 1781 Bathgate Ave.
Dunham, Mrs. E., 29 W. 37th.
‡Dunlevy, Rita, 248 W. 54th.
‡Durkee, Jeannette R., 133 W. 43d.
†‡Durrie, G. B., 79 E. 55th.
†‡Dyer, C. L., 65 W. 36th.
Edwards, Mary L., 25 W. 48th.
*‡Eife, Arthur F., 175 W. 10th.
Eife, Francis, 335 E. 18th.
‡Elebash, Carl P., 228 E. 19th.
*‡Elebash, Clarence S., 228 E. 19th.
‡Elmendorf, T. C., 344 E. 42d.
Ely, L. W., 32 W. 88th.
‡Ermentraut, J. P., 261 E. 4th.
*‡Eurich, C., 119 E. 86th.
‡Ferrier, Jas. M., 1791 Lexington Ave.
‡Finch, Jos., 106 W. 44th.
‡Fleming, Laura M., 57 W. 45th.
Fleming, W. L. 251 W. 54th.
Fletcher, Z. P., 1379 Lexington Ave.
Foster, H. W., Hahnemann Hospital.
Fountain, Mrs. E. J. P., 153 E. 62d.
*‡Fralick, W. G., 745 Madison Ave.
*‡Franklin, E. D., 331 W. 14th.
Fullgraf, Otto, 6 Lexington Ave.
‡Gage, Mary E., 28 W. 45th.
Garrison, H. W., 154 E, 86th.
*‡Garrison, J. B., 111 E. 70th.
Geddes, Annie L. 46 E. 21st.
†‡Gerard, Louise, 149 W. 41st.
‡Gilbert, C. E., 343 W. 23d.
Gilbert, Mrs. M. H., 15 E. 11th.
‡Goodrich, S. W., 458 W. 153d.
*‡Gore, Jennie E. 163 E. 90th.
‡Graham, N. C., 261 W. 34th.
‡Graves, H. S. 109 W. 63d.
Griffith, J. B., Wards Island.
‡Grimm, A. C., 1812 Lexington Ave.
*‡Guernsey, Egbert, 528 Fifth Ave.
†‡Guernsey, Wm. N., 27 W. 52d.
†‡Hallett, G. D., 81 W. 87th.
*‡Hallock, Lewis, 34 E. 39th.
*‡Hamlin, F. W., 231 W. 52d.
‡Hanchett, H. G., 3 W. 29th.
*Hanford, Harold W., 252 W. 57th.
‡Hardy, O. S., 130 W. 104th.
*‡Hathaway, H. S., 142 W. 94th.
‡Harris, J. W., 2414 Second Ave.
Harris, Richard, 2145 Seventh Ave.
Harris, Sallie A., 2145 Seventh Ave.
‡Hart, A. H., 201 E. 23d.
*‡Hartley. W. G., 345 W. 34th.
‡Hayes, Eliza, 452 E. 84th.
*‡Helfrich, C. H., 201 E. 23d.
*‡Helmuth, Wm. Tod, 299 Madison Ave.
*‡Helmuth, W. T., Jr., 41 E. 12th. 465 Lexington Ave.
‡Hiller, J. L., 116 W. 82d.
Hitchcock, Harlyn, 19 Broadway.
Hichcock, Henry M. 38 Park Row.

‡Hofmann, E. F., 45 W. 25th.
Holbrook, M. L., 46 E. 21st.
†‡Honan, W. F. 104 W. 64th.
*‡Houghton, H. C., 7 W. 39th.
‡Howard, C. C., 64 W. 51st.
‡Howe, J. M., 58 W. 47th.
‡Hoyt, E. F., 36 W. 27th.
‡Hull, G. A., 210 W. 11th.
*‡Hunt, D. B., 159 Madison Ave.
*‡Hunt, O. G. 134 E. 19th.
Husson, J., 135 E. 123d.
Jennings, Ella A. 93 Clinton Pl.
Johnson, P. R., 568 Fifth Ave.
†‡Jones, W. H., 202 W. 74th.
‡Keatinge, Mrs. H. C., 136 W. 48th.
‡Keatinge, Harriette d'E., 136 W. 48th.
‡Keep, Mrs. C. J. Y. 308 W. 36th.
*‡Kellogg, E. M. (not practicing) 115 E. 37th.
*‡King, W. H., 23 W. 53d.
King, W. N., 214 W. 44th.
‡Krause, W. H., 329 E. 14th.
‡Laidlaw, A. H., 137 W. 41st.
Laidlaw, G. F., 137 W. 41st
*‡Land, J. F., 130 W. 126th.
‡Lannin, Louise, 240 W. 48th.
La Roche, P., 202 W. 31st.
*‡Leal, Malcolm, 144 W. 48th.
Lewis, N. H., 224 E. 23d.
‡Linsley, J. S., 65 W. 70th.
‡Livor, J., 74 Fifth Ave.
Lloyd, A. H., 591 E. 141st.
Lozier, J. De laM., 154 W. 78th.
‡Mac Bride, N. L., 114 W. 47th.
*‡Mac Ivor, Abbie H., 2151 Seventh Ave.
Mac Ivor, James H., 2151 Seventh Ave.
†‡Macy, C. S., 117 W. 12th.
‡Maeder, J. G., 304 E. 120th.
Mann, Mrs. M. F., 359 Lexington Ave.
Marcy, E. E., 353 Fifth Ave.
Martin, K. B., 61 W. 11th.
Martine, Jeannie W., 16 W. 61st.
†‡McDonald, R. E., 2065 Madison Ave.
‡McDonald, W. O., 117 W. 44th.
*‡McDowell, C., 116 W. 13th.
*‡McDowell, G. W., 151 W. 130th.
*‡McMichael, A. R., 969 Madison Ave.
*‡McMichael, D. A., 61 W. 97th.
†‡McMichael, J. E., 23 E. 126th.
*McMnrray, R., 234 Second Ave.
Merritt, Adelaide E., 247 W. 21st.
Miller, C. H., 39 Jane.
Miller, E. P., 39 W. 26th.
Miller, J. F. 324 W. 57th.
‡Miller Martha F., 213 W. 54th.
Miller, Nancy M., 41 W. 26th.
*‡Miner, W. S., 337 Alexander Ave.
‡Morgan, A. R.. 105 E. 82d.
Morgan, G. E., 44 E. 124th.
Morgan Laura, 209 W. 118th.
*‡Mossman, N. A., 350 Madison Ave.
‡Mount, Margt. A. B., 574 Lexington Ave.
‡Müller, C. W., 225 E. 83d.
*‡Musits, H. von, 1266 Lexington Ave.
‡Newcomb, O., 233 E. 12th.
Noble, D. C., Flower Hospital.
*‡Norton, A. B., 146 W. 34th.
*‡Nott, F. J., 500 Madison Ave.
*‡Noxon, Mary W., 28 W. 45th.
Nutter, Mary E., 231 E. 26th.

Oakey, Mrs. Fannie W., 665 Lexington Ave.
Oatman, L. H., Ward's Island.
‡O'Brien, Evelina C. D., 226 E. 87th.
†‡Ogden, E. G., 451 West End Av.
*‡O'Connor, Mrs. H. M. C., 18 W. 43d.
*‡O'Connor, J. T., 18 W. 43d.
†‡Oertel, G. F., 404 W. 22d.
*‡Ostrom, H. I., 42 W. 48th.
*‡*Paige, H. W.*, 320 W. 28th.
†‡Palmer, A. W., 101 W. 81st.
Palmer, J. B., Ward's Island.
†‡Palmer, Miles W., 235 E. 18th.
‡Pardee, E. B., 218 W. 34th.
Pardee, W., 218 W. 34th.
‡Parker, A. H., 116 E. 59th.
‡Patchen, G. H., 71 E. 59th.
Patton, H. M., 488 St. Nicholas Ave.
*Pearsall, S. J., 128 W. 78th.
†‡Pearsall, W. S., 128 W. 78th.
*Pease, Chas. G., 101 W. 72d.
Peterson, W., 656 Madison Ave.
‡Pettet, Mrs. E. B., 308 E. 15th.
Piatti, V., 148 W. 16th.
*‡Pierce, W. Ide, 64 W. 126th.
Piersons, A. M., 24 E., 127th.
Pomeroy, T. F., 130 W. 23d.
Porter, C. W., Ward's Island.
*‡Porter, E. H., 181 W. 73d.
*‡Pratt, E. J., 7 W. 39th.
*‡Queen, L. A., 492 W. 153d.
*‡Rabe, F. E., 227 W. 42d.
‡Rankine, E. G., 528 Fifth Ave.
‡Rannefeld, A. H., 85 Seventh.
Raymond, H. L., Ward's Island.
*‡Reynolds, W. U., 224 Second Ave.
*‡Richardson, A. J., 39 E. 83d.
‡Richardson, B. M., 200 W. 57th.
*‡Richardson, G. W., 138 E. 79th.
‡Ring, T. S., 152 E. 82d.
*‡Roberts, G. W., 137 W. 34th
‡Robinson, J. B., 720 Lexington Ave.
‡Roder, Mrs. L. B., 229 E. 82d.
*‡Rounds, W. E., 154 W. 47th.
*‡Russell, H. E., 57 E. 76th.
St. John, A. H., 233 E. 69th.
*‡Schley, J. Montfort, 1 E. 42d.
*‡Scott, W. H., 102 W. 44th.
*Seegar, F., 718 Lexington Ave.
Sell, E. H. 44 W. 49th.
‡Sewall, S. G., 1686 Madison Ave.
†‡Sheldon, F. P., 237 W. 127th.
*‡Shelton, G. G., 251 Madison Ave.
*‡Shepard, G. A. 152 W. 34th.
‡Sherman, L. B., 351 W. 14th.
†‡Simmons, R. S., 129 E. 59th.
*‡Simonson, J. T., 61 E. 83d.
Sinsabaugh, J. A., 672 Second Ave.
‡Smith, G. B., 35 E. 28th.
*‡Smith, Henry M., 21 W. 24th.
Smith, Max M., 219 E. 81st.
Smith, N. Jr., 151 W. 48th.
‡Smith, Roswell D., 1265 Lexington Ave.
‡Smith, Sarah N., 135 W. 34th.
*‡Smith, St. Clair, 8 W. 38th.
*‡Smith, T. F., 264 Lenox Ave.
‡Smyth, S. H., 114 E. 10th.
Stanton, Kate, Madison Ave. Hotel.
‡Stanton, L. M., 181 W. 87th.
‡Stevens, Anna C. R., 247 W. 42d.
Stevens, D. D., 170 W. 54th.
Stewart, G. T., Ward's Island.
Still, Emma R., 275 W. 22d.

*‡Storer, J. H., 30 Edgecombe Ave.
*Strong, C. H., 34 W. 32d.
*‡Sturtevant, Euphemia J., 362 W. 19th.
Swan, Samuel.
‡Talcott, S. Eliza, 223 W. 135th.
†‡Talcott, W. S., 223 W. 135th.
*‡Teets, C. E., 217 W. 23d.
‡Terry, J. A., 236 W. 44th.
†‡Thompson, J. H., 36 E. 30th.
*‡Thompson, V., 161 W. 13th.
‡Thomson, J. W., 136 W. 16th.
‡Tinker, H. H., 1257 Washington Ave.
*‡Townsend, Irving, 66 W. 46th.
‡Townsend, Katherine G., 354 W. 123d.
Turner, Jno., 309 W. 13th.
*‡Tuttle, E. G., 66 W. 46th.
*‡Tytler, G. E., 113 W. 126th.
*‡Vehslage, S. H., 313 E., 18th.
Van Loon, A. B., Ward's Island.
†‡Ver Nooy, Chas., 148 W. 64th.
†‡Wait, Phebe, J. B., 9th Ave. cor. 34th.
*Weed, R. M., 132 E. 45th.
‡Welch, F. G., 146 W. 43d.
Wellman, W. I., 109 E 86th.
‡West, Edwin, 38 W. 12th.
*‡Wetmore, J. McE., 41 E. 29th.
*‡White, A. Lenora, 110 W. 44th.
*‡White, J. Ralsey, 1944 Madison Ave.
‡White, W. H., 56 W. 48th.
†‡White, W. Storm, 56 W. 48th.
‡Whittemore, Margaret, 411 W. 22d.
Wickes, C. M., Ward's Island.
*‡Wilcox, S. F., B'way, cor. 57th.
‡Wilder, L. de V., 55 W. 33d.
†‡Williams, Cordelia, 30 E. 22d.
*‡Williams, T. C., 154 W. 47th.
*‡Winterburn, G. W. 230 W. 132d.
‡Wood, J. R., 143 W. 76th.
‡Woodward, A. M., 155 W 12th.
Woodward, Ellen E., 213 W. 54th.
‡Woolley, Charlotte H., Railroad Ave. cor. 160th.
‡Worrall, M. Ruth, 239 E. 12th.
‡Wright, Amelia, 24 W. 59th.
‡Wright, P. W., 72 Seventh Ave.
‡Wylie, Louise L., 135 W. 34th.
‡Young, Chas. H., 319 W. 44th.
‡Zabriskie, Gertrude, L., 259 W. 52d

NIAGARA COUNTY.

(County Society Moribund.)

GASPORT.

Knapp, F. H.

LOCKPORT.

Evans, A. J.

*Hurd, S. W., 234 Genesee.

Pettit, W. M.

MIDDLEPORT.

Robertson, Mrs. H. M.

NIAGARA FALLS.

Hodge, J. W.

*Hough, D. D.

NORTH TONAWANDA.

*Blighton, W. V-R., (Lic. Columbia and Greene Co. Society).

ONEIDA COUNTY.

BOONVILLE.

‡Guile, E. B. ‡Warren, W.

CLINTON.

‡Dever, I.

ROME.

‡Gifford, Alden ‡Scudder, S. O.
‡Scudder, N. C. *‡Southwick, A. B.
‡Tousley, R. F., 203 W. Dominick.

TRENTON.

‡Spencer, R. L.

UTICA.

Chandler, D. H. ‡Moore, J. deV., Steuben Pk.
*‡Chase, C. E., 230 Genesee. *‡Terry, M. O., 196 Genesee.
Cooper, C. G., 8 Carlisle Block. *‡Watson, W. H., 270 Genesee.
‡Hennessy, Margaret E., 84 Second. *‡Wells L. B., 148 Park Ave.
*‡White, Sue A., 240 Genesee.
†*‡Laird, F. F., 190 Genesee.

WATERVILLE.

††Dean, L. W. Taft, F. P.

ONONDAGA COUNTY.

BALDWINSVILLE.

‡Burch, J. H. ‡Martin, Leslie

ELBRIDGE.

‡Warren, Erastus

FAYETTVILLE.

Badgely, C. ‡Hutchinson, P.

JORDAN.

Warren, S. C.

LIVERPOOL.

‡Young, J. R.

MEMPHIS.

‡Sullivan, N. B. Willer, A. M.

PLAINVILLE.

‡Hooker, Frederick

SKANEATELES.

*‡Martin, G. Forrest

TULLY.

Barker, G. E.
Leonard, H. W.

WARNER STATION.

‡Anthony, B. A.

ONONDAGA VALLEY.

Rudolf, Kaiser

SYRACUSE.

‡Brewster, A. J., 211 Shonnard.
*‡Candee, J. W., 402 Warren.
Cooper, C. S., 220 Shonnard.
Crowell, L. C., 915 East Fayette.
DuBois, C. Willard, 357 Warren.
‡Emens, Harriet D., 321 Montgomery.
‡Flint, E. H., 1624 West Genesee.
‡Hale, C. D., 311 Warren.
*Hallock, J. H. 414 South Salina.
†‡*Keeler, E. E.*, 414 South Salina.
*‡Kinne, A. B., 413 Warren
‡Kinne, E. O., 311 Warren.
‡Leggett, Mrs. L. L., 329 James.
‡Lukens, C. M., 347 Warren.
‡Nottingham, John, 7 Greeley Block.
‡Putnam, F. D., 310 East Fayette.
‡Scheumacher, Carl, 708 North Salina.
‡Seward, Stephen, 504 West Onondaga.
*‡Sheldon, J. W., 402 Warren.
†‡Sherwood, B. W., 1117 South Salina.
Stephens, C. E., 303 North Salina.

ONTARIO COUNTY.

CANANDAIGUA.

†‡Mitchel, C. T.
‡Voak, J. B.
‡Warner, P.

CLIFTON SPRINGS.

*‡Foster, Henry
*Wilcox, F. P.

EAST BLOOMFIELD.

*‡Partridge, Barton S.

GENEVA.

*‡Covert, N. B.
*Dake, Mrs. B. F.
*‡Knapp, James C.
McKenzie, J. E.
‡Smith, A. B.
*‡Stebbins, J. H.

NAPLES.

Conley, D. C.

OAKS CORNERS.

*‡Church, G. H., (Lic., Ontario and Yates Co. Society.)

PHELPS.

*‡Prichard, G. C.

PORT GIBSON.

*Throop, A. P.

SHORTSVILLE.

‡Cooke, J. D.

VICTOR.

*Rowley, C. A.

ORANGE COUNTY.

CORNWALL-ON-HUDSON.

*Bergen, A. W.

GOSHEN.

††‡Ostrom, J. W.

*‡Seward, F. W.

MIDDLETOWN.

*Allen, George
‡*Arthur, Daniel H.,
‡Bradner, Ira S.,
‡Bradner, Julia A.

*‡Fancher, E., 16 Orchard.
Hammer, J. La T., 6 Low Block.
*‡Kinney, C. Spencer.
*‡Talcott, Seldon H.

MONROE.

†Day Geo. H.

MONTGOMERY.

*‡Wallace, Wm. I.

NEWBURGH.

Clock, Sarah I.
*‡*Jacobson, F. A.*

*‡Mitchell, J. J.
Winans, H. E.

PORT JERVIS.

‡Best, Fred'k W.

‡Lambert, E. B.

SLATE HILL.

Carpenter, A. J.

WALDEN.

‡Faulkner, W. H.

WARWICK.

‡Cummins, Frank M.

OSWEGO COUNTY.

FULTON.

Woodbury, W. C.

MEXICO.

*‡Radway, C. W.

Rundell, Harriet (Lic.)
Stow, T. D.

OSWEGO.

††‡Hinman, E. L., 84 West Oneida.
*‡Keeney, J. H., 210 West First.
*‡*McManus, G. D.*, 33 East Bridge.
Richards, L. B., East Bridge and Second.

PALERMO.

Woodruff, M. R. (Lic.)

PHŒNIX.

Smith, Gerrit (Lic.)

‡Young, ——

PULASKI.

††‡Adams, G. F.

WILLIAMSTOWN.

Ball, G. R.

OTSEGO COUNTY.

COOPERSTOWN.

*Babbitt, Otis H.
Blodgett, T. S.

EXETER.

Chappell, Charles

HARTWICK.

Luce, Daniel

MORRIS.

Matison, Merritt

ONEONTA.

Brown, M. S., 207 Main.
*Getman, A. D.

OTSEGO.

Cassart, James

RICHFIELD SPRINGS.

Getman, Norman

UNADILLA.

Clark, P. G.

PUTNAM COUNTY.

(‡Westchester County Society.)

BREWSTER.

*‡Strunk, E. P.

PATTERSON.

*Birdsall, Thomas P.

QUEENS COUNTY.

FLUSHING.

Allen, Wm. A., Bowne Ave.
Gill, J. W.

GLEN COVE.

Watson, Henry B.

HEMPSTEAD.

Lount, Robert, 79 Fulton.

JAMAICA.

Belden, Clinton A.
Belden, Charles K.

LONG ISLAND CITY.

Finerty, J. W., 134 Third.
Platt, C. N., 152 Franklin. (Astoria.)

SEAFORD.

Ermentraut, A. O.

WOODHAVEN.

Macfarland, R. L.

RENSSELAER COUNTY.

CASTLETON.

Welch, C. D.

EAGLE BRIDGE.

Rider, E. H.

GREENBUSH.

Miller, Horace C., 78 Broadway.

HOOSICK.

Putnam, W. E.

HOOSICK FALLS.

Hudson, F. R.
Lamb, G. M.
Putnam, W. B.
*Shaw, J. C.

LANSINGBURGH.

Homes, H. P., 512 Second Ave.

TROY.

Bailey, C. L. 570 River.
*Benson, R. F., Jr., 2 St. Paul Place.
Belding, R. E., 2141 Fifth Ave.
Bloss, F. S., 108 Second.
Bloss, Jabez P., 108 Second.
Bloss, Richard D., 1810 Fifth Ave.
Campbell, M. W., 1832 Fifth Ave.
*Coburn, E. S., 91 Fourth.
*Crandall, E. L., 1943 Fifth Ave.
Green, A. R., 17 Second.
*Waldo, H. L., 1834 Fifth Ave.

RICHMOND COUNTY.

NEW BRIGHTON.

Donavan, Fanny C., 9 York.

TOTTENVILLE.

Coleman, David

WEST NEW BRIGHTON.

Bryan, Wm.
Robinson, Samuel A.

ROCKLAND COUNTY.

NYACK.

Couch, L. B.
Giles, J. Wm.

ST. LAWRENCE COUNTY.

BRIER HILL.

Graves, F. E.

CANTON.

Gleason, Willis W.
Russell, G. A.
*Williams, Frank F., 6 Goodrich.

COLTON.

Bottsford, L. T.

DEKALB.

Cole, E. M.

GOUVERNEUR.

Baldwin, G. W. Flint———
Guyott, E. J.

MASSENA.

Stearns, M. J.

NORWOOD.

Smith, C. W.

OGDENSBURGH.

*†‡Bell, W. N., 6 Greene. Child, N. N.
*Southwick, D. E.

POTSDAM.

Britton, J. E. Brown, H. D.

STOCKHOLM DEPOT.

Austin, E. C.

WINTHROP.

*Marsh, J. M.

SARATOGA COUNTY.

BALLSTON SPA.

Royal, T. Cook

BATCHELLERVILLE.

Anderson, J. K.

MECHANICVILLE.

La Dow, Chas. H.

SARATOGA SPRINGS.

Ayres, Mrs. Travers, O. J.
*Pearsall, John A. Wilson, Mary L. D. 121 Circular

WATERFORD.

Peckham, A. G.

SCHENECTADY COUNTY.

SCHENECTADY.

Bates, Geo. W. Kastendieck, John, 442 State.
*‡Faust, Louis, 148 Jay. *‡Spoor, D. E., 170 Lafayette.

SCHOHARIE COUNTY.

(No Homœopathist.)

SCHUYLER COUNTY.

LOGAN.

Tracy, G. A.

MECKLENBURGH.

Stobbs, A. V.

WATKINS.

*Gulick, Wm.

SENECA COUNTY.

CANOGA.

‡Frantz, A. J.

FARMER VILLAGE.

‡Otis,———

OVID.

‡Horton A.

SENECA FALLS.

*‡Covert, R. B.
†*Follett, W. M., 36 Cayuga.
‡Heath, H. H.
‡Weatherlow, Mrs. C. M.

WATERLOO.

‡Drake, M. S.
‡*Peterson, O. W.*

STEUBEN COUNTY.

BATH.

Grant, B. F.

CANISTEO.

Sutton, Frank W.

CORNING.

*Bryan, E. W.
*Hawley, Geo. T.
*Purdy, Mark S.
Purdy, W. S.
*Wellington, J. F., 12 Market.

HAMMONDSPORT.

Horton,———

HORNELLSVILLE.

*Hathaway, W. E.

WAYLAND.

Piatt, A. A.

SUFFOLK COUNTY.

(No County Society.)

BABYLON.

*Woodruff, A. J., 32 Main.

BAY SHORE.

*Foster, Wm. E.

GREENPORT.

Ireland, T. L.

HUNTINGTON.

Sword, Geo. P.

PATCHOGUE.

*Pettit, A. R., Main. *Foster, E. A., Ocean Ave.

RIVERHEAD.

Hartranft, John E.

SOUTHOLD.

Hartranft, Joseph

SULLIVAN COUNTY.

(No Homœopathist.)

TIOGA COUNTY.

(No County Society.),

CANDOR.

Roper, W. E.

NEWARK VALLEY.

*Bishop, Frank M.

OWEGO.

*Dutcher, Merritt T. *Greenleaf, J. T., 101 Main.

Purcell, James P.

WAVERLY.

Hilton, W. M. Millspaugh, C. F.

TOMPKINS COUNTY.

ETNA.

Rood, ———

GROTON.

Baldwin, A. M.

ITHACA.

Besemer, Martin Morgan, E. J.

Bishop, Alonson Parker, S. J.

*Van Cleef, C. E., 49 E. State.

LUDLOWVILLE.

Barr, Wm. H.

TRUMANSBURG.

Carpenter, L. W. Tallmadge, Rufus

ULSTER COUNTY.

(County Society Moribund.)

CLINTONDALE.

Birdsall, W. G.

ELLENVILLE.

Harris, Nelson A. Smith, Henry C.

KINGSTON.

Chalker, A. P., Rondout. Eckert, Edward O'N.
Connolly, Harry McEntee, Sarah, Rondout.
*Decker, W. M. *Montanye, W. De L., Rondout.
*Shafer, Levi.

NEW PALTZ.

Gerow, Stephen W.

STONE BRIDGE.

Van Dermark, John

WARREN COUNTY.

GLENS FALLS.

*Birdsall, S. T., 142 Ridge. *Bullard, D. H., 11 Elm.
*Little, G. W.

BOLTON.

*Stiles, Henry R., Hill View.

WASHINGTON COUNTY.

(No County Society.)

CAMBRIDGE.

*Clark, L. A. *Lewis, F. Edward
Niver, J. F.

EASTON.

Mosher, E. E.

FORT ANN.

Mott. O. H.

FORT EDWARD.

Linnendale, R. A. Pattee, Raymond
*Van Denburg, M. W.

GRANVILLE.

Mosher, B. D.

GREENWICH.

Hulst, Peter H.

NORTH GRANVILLE.

*Spoor F. W.

SANDY HILL.

Infield, Clifton L.

Mott, Albert.

Van Derworker, H. W.

WHITE CREEK.

Turner, G.

WHITEHALL.

Horton, E. T.

WAYNE COUNTY.

(Society Moribund.)

CLYDE.

‡Childs, G. C.

Hartman, ———

‡Sayles, E. M.

LYONS.

Cole, ———

Read, J.S.

‡Sherman, S. D.

MARION.

Halstead, ———

NEWARK.

‡Parson, O. C.

‡Reed, J. A.

Kelly, L. S.

‡Thatcher, E. P.

ONTARIO.

‡Peer, ———

PALMYRA.

‡McPherson, D.

SAVANNAH.

*‡*Sweeting, W. H.*

SODUS.

‡Whittleton, E. J.

SOUTH BUTLER.

‡Sweeting, M. F.

Sweeting, S. C.

WALWORTH.

Rodenburger, ———

WILLIAMSON.

‡Austin, A. G.

*Clark, Frank Wake

WESTCHESTER COUNTY.

DOBB'S FERRY.

‡Hasbrouck, Joseph

MAMARONECK.

*‡Hall, Matthew J.

White, Ellen M.

MT. KISKO.

‡Miller, Carlos J.

MT. VERNON.

‡Ferris, I. W., 149 S. Third Ave. ‡Jones, H. C., 220 S. First Ave.
‡Hollister, Q. A., 126 S. 5th Ave. ‡Nutting, N., 210 S. Second Ave.
White, F. R. S.

NELSONVILLE.

‡Winslow, W. J.

NEW ROCHELLE.

‡Finch, E. W., Center Ave. and Prospect. Jenkins, Charlotte
‡Kellogg, Fannie H., 172 Huguenot.
*‡Roberts, D. J.

NORTH TARRYTOWN.

*‡Brown, E. V.

PEEKSKILL.

‡Mason, Perley H., 734 South.

PLEASANTVILLE.

*‡Swift, E. P.

PORTCHESTER.

*White, J. C.

SHRUB OAK.

Dresser, G. D.

SING SING.

*‡Lane, Irwin J., 2 Church. Schafmeister, J. A
*‡Madden, Joel D. ‡Secor, I. R.

TARRYTOWN.

‡Fanning, T. C.

WHITE PLAINS.

Birch, Chas. E. *Hanor, Azro Chace
Haight, A. M. ‡Kingsley, O. D.

YONKERS.

*‡*Fay, R. P.*, 80 Warburton Ave. *†‡Philips, R. O., 257 Warburton Ave.
*‡Flagg, R. N., 118 S. Broadway. ‡Stillwell, B. W., (not practicing).
‡Nobles, Elizabeth, 47 S. Broadway. *‡Trotter, R. R., 189 Warburton Ave.

WYOMING COUNTY.

(‡Livingston County Society.)

ATTICA.

*Gifford, W. B.

PERRY.

‡Trover, G. R.

WARSAW.

Rickett, Mrs. Emeline

*Slaught, J. E.

Smith, Thad. B.

WYOMING.

Wadsworth, Robert

YATES COUNTY.

CRYSTAL SPRINGS.

*Rogers, E. W.

ITALY HOLLOW.

Smith, E. D.

PENN YAN.

Sampson, F. S.

Tompkins, F.

INDEX.

PAGE.

Acetanilide Poisoning, - - - - - - - - - 144
"Adenoid Growths, Some Suggestions on, in the Naso-pharyngeal Space," by J. M. Schley, - - - - - - - - - - 276
ADRIANCE, F. W., "A Case of Pudendal Hæmatoma," - - - - 229
'Advisability of Laws Further Regulating Marriage," by Wm. M. L. Fiske, - 151
Agaricus in a Case of Paralysis of the Eyelids, - - - - - 75
ALLEN, GEORGE, "The Situation at Middletown," - - - - 367
ALLEN, T. F., Report on Cedron, 162; Remarks, - - - 33, 34. 185
"Amyl Nitrite in Heat Flushings," by H. M. Hicks, - - - - 180
"Anal Sphincter Stretching," by Wm. M. L. Fiske, - - - - 138
"Anus, The Rectal Mucous Membrane as a Means of Preventing Infection in Operations About the, by Wm. B. Van Lennep, - - - - 225
Annual Meeting, - - - - - - - - - 7
"Appendicitis, Three Cases of,—No Appendix," by S. F. Wilcox, - - 345
"Asthma, a Result of Pleuritic Effusion," by W. S. Garnsey, - - - 186
Attendance, - - - - - - - - - - 13, 160
Banquet, - - - - - - - - - - 31, 163
BAYLIES, B. L'B., "Verification of Culex Musca, (Mosquito)," - - - 187
BETTS, B. F., The Responsibility of the Physician in the Treatment of Obscure Pelvic Disorders in Women," 215; Remarks, - - - - 218
BIEGLER, J. A., resigned, - - - - - - - - 15
BIGGAR, H. F., Remarks, - - - - - - 213, 224, 351
BISSELL, E. J., "A Comparison of Tests in Heterophoria," 60; "Observations with Javal's Ophthalmometer," 296; Remarks, - - - 67, 73, 314
Board of Medical Examiners, - - - - - 6, 35, 411, 429
BOOCOCK, ROBERT, Reinstated, 32; Remarks, - - - - 219, 256
BOYLE, CHAS. C., "Three Cases of Retrobulbar Neuritis," 73; "A Case of Nuclear Iridoplegia," - - - - - - - - 332
"Bright's Disease, Some Observations upon, especially Interstitial Nephritis," by F. F. Laird, - - - - - - - - - - 177
BULL, L. A., "A Case of Intubation," 50; "Rational Treatment of the Nose and Throat," 274; Remarks, - - - - - 29, 279, 284
Bureaus.—See their respective titles.
BUTLER, W. M., "Disorders of Digestion in their Relation to Mental and Nervous, Disease," 89; "The Colonization of Epileptics," 269; Remarks, - - - - - - - - 16, 34, 84, 185
By-Laws, Proposed Amendments, - - - - - - 33, 167
"Cæsarian Section," by Harrison Willis, - - - - - - 135
CALDWELL, FRANK E., "Special Therapeutics of Static Electricity," 256; Remarks, - - - - - - - - - - 214
CARR, ALLEN B., dropped, - - - - - - - - - 14
CASSIDY, GEORGIA A., "The Leucorrhœa of Children," - - - 199
Cedron, Report on Provings of, by T. F. Allen, - - - - - 162
Censors, Report of Board of, - - - - - - 12, 32, 159

CHASE, J. OSCOE, "Stomatitis," - - - - - - - 205
"Chorea, Three Cases," by L. A. Frazier, - - - - 182
CHURCH, CHARLES A., "Orificial Surgery in the Cure of Mental Disease," - 263
CLARK, B. G., Remarks, - - - - - - 184, 229, 268
Clinical Medicine, Bureau of, - - - - - - 141, 177
College, Entertained at the, - - - - - - - 162
Committees—See their respective titles.
Constitution and By-Laws, 419; Amendments, - - - - 28, 32, 33
COVERT, N. B., Nominated for the Regent's Degree, - - - 30, 33
"Culex Musca (Mosquito), Verification of," by B. L'B. Baylies, - - 187
DANFORTH, L. L., Remarks, - - - - - - - 255
DEADY, CHAS., Remarks, - - - - - - 29, 67, 68, 313, 314
Deaths during the year, - - - - - - - - 429
Delinquent List, 432; Legal opinion about, - - - - - 28
"Diphtheria," by J. B. Garrison, - - - - - - 272
Directory of Homœopathic Practitioners in N. Y. State, - - - 447
"Disorders of Digestion in their Relation to Mental and Nervous Disease," by W. M. Butler, - - - - - - - - 89
"Drainage after Laparotomy," by Homer I. Ostrom, - - - - 219
"Electricity in Diseases of the Eye," by A. B. Norton, - - - - 68
"Electricity for Removing Facial Blemishes," by W. H. King, - - - 351
"Epileptics, The Colonization of," by W. M. Butler, - - - - 269
"Eye Strain, Reflex Neuroses from," by A. B. Norton, - - - - 314
"Facial Blemishes, The Removal of, by Electricity," by Wm. H. King, - - 351
FISKE, WM. M. L., "Anal Sphincter Stretching," 138; Presidential Address—"The Advisability of Laws Further Regulating Marriage," 151; Biographical Sketch, 417; Remarks, - - - - - - 150, 268
"Forceps, The, and Occipito-posterior Positions," by Edwin H. Wolcott, - 235
"Fourth Stage of Labor, The," by G. W. Winterburn, - - - - 240
FRAZIER, L. A., "Three Cases of Chorea." - - - - - - 182
GARNSEY, W. S., "Asthma, a Result of Pleuritic Effusion," - - - 186
GARRISON, J. B., "A Plea for Accurate Symptom-prescribing n Diseases of the Throat, Nose and Lungs," 52; "Diphtheria - - - - 272
GIFFORD, ALDEN, dropped, - - - - - - 159
GIVENS, AMOS J., "Hæmatoma Auris," - - - - - 84
GORHAM, GEO. E., Report - - - - - - - - 167
GRAHAM, M. E., Remarks, - - - - - - - - 16
GREENLEAF, J. T., "Insanity as a Ground for Divorce," - - - 81
GWYNN, CHAS. A., dropped, - - - - - - - - 14
Gynæcology, Bureau of, - - - - - - - - 207
"Hæmatoma Auris," by A. J. Givens, - - - - - - 84
Hahnemann Statue, - - - - - - - - - 165
HALLOCK, J. H., "My Personal Experience with the Female Perinæum." - 238
"Has it been an Oversight?" by M. W. Van Denburg, - - - - 145
"Heart Disease, Prognosis in Organic," by J. M. Schley, - - - 189
"Heterophoria, A Comparison of Tests in," by E. J. Bissell, - - - 60
HICKS, H. M., "Amyl Nitrite in Heat Flushings," - - - - 180
HILL, C. JUDSON, Obituary of, - - - - - - - - 17
HOLDEN, A. W., Obituary of, - - - - - - - - 22
HOUGHTON, HENRY C., "Sound as a Factor in the Treatment of Disease of the Sound-conducting Apparatus," - - - - - - - 334

"Hyoscyamine Hydrobromate," by John L. Moffat, - - - - 65
"Hysterectomy, How far has the performance of, proven itself a justifiable procedure," by G. C. Jeffery, - - - - - - - 118
HURD, EDWIN H., Obituary of, - - - - - - - 20
"Influence of Music on the Insane," by C. Spencer Kinney, - - - 79
"Insanity as a Ground for Divorce," by J. T. Greenleaf, - - - 81
"Interstitial Nephritis, Some Observations upon Bright's Disease, especially," by F. F. Laird, - - - - - - - 177
"Intubation, a Case of," by L. A. Bull, - - - - - 50
Investigation of Drug Effects, Report of Committee on, - - - 15
"Iridoplegia, A Case of Nuclear," by C. C. Boyle, - - - - 332
"Javal's Ophthalmometer, Observations with," by E. J. Bissell, - - - 296
JEFFERY, GEORGE CLINTON, "How far has the Performance of Hysterectomy Proven Itself to be a Justifiable Procedure?" 118; Remarks, - - 127
JENKS, F. PERCY, "Sulphonal Homœopathically Considered, - - - 86
KEELER, E. E., Discussion, - - - - - - - 337
"Kidney, Malposition of the, Discriminated from Pelvic Growths—A Case," by A. Lenora White, - - - - - - - - 207
"Kidney, Movable, and Nephrorrhaphy," by S. F. Wilcox, - - - 128
KING, WILLIAM HARVEY," The Removal of Facial Blemishes by Electricity," - 351
KINNE, Theodore Y., Nominated for Honorary Membership, - - - 30
KINNEY, C. SPENCER, "Influence of Music on the Insane," - - - 79
LAIRD, F. F., "Some Observations upon Bright's Disease, Especially Interstitial Nephritis," - - - - - - - - - 177
Laryngology and Rhinology, Bureau of, - - - - - 50, 272
LEE, J. M., Remarks, - - - - - - - - 16
Legal Opinion About Publishing our Delinquent List, - - - - 28
Legislation, Report of Committee on, - - - - 167, 367, 376
LEHMAN, F. F., "A Radical Cure for Retro-displacements of the Uterus," - 114
"Lens, Dislocation and Cataract of the, by a Shot from an Air Gun," by A. G. Warner, - - - - - - - - - 332
"Leucorrhœa of Children," by Georgia A. Cassidy, - - - - 199
LEWIS, F. Park, Presidential Address, 7; Remarks, - - - - 184
LEWIS, GEO. W. Jr. Dropped, - - - - - - - 14
LINNELL, E. H., "A case of Paralysis of the Eyelid, Exhibiting some Peculiar Features, cured by Agaricus," 75; "Senega in the Treatment of Hyperphoria and its Resultant Symptoms," - - - - 321
LONG, WM. E., dropped, - - - - - - - - 14
MADDEN, J. D., Remarks, - - - - - - - - 185
"Marriage, Advisability of Laws Further Regulating," by Prest. Fiske, - - 151
Materia Medica, Bureau of, - - - - - 34, 145, 162
MCPHERSON, J. C., Dropped, - - - - - - - 14
Medical Examiners, State, - - - - - - 6, 35, 411, 429
Members, Dropped, - - - - - - 14, 159, 432
——— Honorary, - - - - - - - - 428
——— Delegate, - - - - - - - - 443
——— Delinquent, - - - - - - 14, 27, 28, 432
——— Permanent, - - - - - - 12, 159, 433
Mental and Nervous Diseases, Bureau of, - - - - 79, 256
"Middletown, The Situation at," by George Allen, - - - - 367
Midwives, Committee on, 15; Law affecting, - - - - - 163

MINTON, HENRY B., "Fracture of the Base of the Skull, with Delayed Symptoms," 343
MOFFAT, JOHN L., "Hyoscyamine Hydrobromate," 65; Resolution, 163; Remarks, - - - - - - 16, 27, 30, 67, 163, 167, 185, 351
"Monobromacetanilide, Remarkable toxic effects of a small dose of," by J. M. Schley, 141
MOORE, J. de V., dropped, - - - - - - - - - 14
MOSHER, CHAS. M., dropped, - - - - - - - - 14
"Mouth and Throat, Syphilis of the, with Treatment," by H. W. Paige, - - 285
Necrologist's Report, - - - - - - - - - - 17
"Nephrorrhaphy, with a report of two operations for Movable Kidney," by S. F. Wilcox, - - - - - - - - - - 128
Nominations, - - - - - - - - - - 16, 30
NORTON, A. B., "Electricity in Diseases of the Eye," 68; "Reflex Neuroses from Eye Strain," 314; Remarks, - - - - - - 29, 34, 73
"Observations with Javal's Ophthalmometer," by E. J. Bissell, - - - 296
"Obstetrical Annoyances," by E. H. Wolcott, - - - - - 93
Obstetrics, Bureau of, - - - - - - - - 93, 234
Officers, - - - - - - - - - - 4, 5, 33, 430
Ophthalmology and Otology, Bureau of, - - - - - 60, 296
"Ophthalmometer, Observations with Javal's," by E. J. Bissell, - - - 296
"Organic Heart Disease, Prognosis in," by J. M. Schley, - - - - 189
"Orificial Surgery in the Cure of Mental Diseases," by C. A. Church, - - 263
OSBORNE, NEHEMIAH, reinstated, - - - - - - - - 34
OSTROM, HOMER I., "Drainage after Laparotomy," - - - - 219
OTIS, CLARK, dropped, - - - - - - - - - 14
Paedology, Bureau of, - - - - - - - - - 199
PAIGE, H. WORTHINGTON, "Rhinitis Membranosa, 54; "Syphilis of the Mouth and Throat, with Treatment, 285; Remarks, - - - 284, 285
PAINE, H. M., Remarks, - - - - - - - 35, 218, 219
"Paralysis of the Eyelids, A Case, Cured by Agaricus," by E. H. Linnell, - 75
"Perinæum, My Personal Experience with the Female," by J. H. Hallock, - 238
"Perinæum, The, in its Relation to Normal Labor," by G. W. Winterburn, - 245
"Plea for Accurate Symptom-prescribing in Diseases of the Throat, Nose and Lungs," by J. B. Garrison, - - - - - - - - - 52
"Position an Important Factor in the Management of Parturient Cases," by W. H. Proctor, - - - - - - - - - - 234
Presidential Address, 7, 151; Report of Committee on, - - - 31, 164
PROCTOR, W. H., "Position an Important Factor in the Management of Parturient Cases, - - - - - - - - - - 234
"Prognosis in Organic Heart Disease," by J. M. Schley, - - - 189
"Promiscuous Cases in Gynæcology and Surgery," by Harrison Willis, - - 360
Public Health, Bureau of, - - - - - - - - 169
"Pudendal Hæmatoma, A Case of," by F. W. Adriance, - - - 229
"PURDY, MARK S., Reinstated, - - - - - - - - 15
"Rational Treatment of the Nose and Throat," by L. A. Bull, - - 274
"Rectal Mucous Membrane as a Means of Preventing Infection in Operations about the Anus," by Wm. B. Van Lennep, - - - - - 225
"Reflex Neuroses from Eye Strain," by A. B. Norton, - - - - 314
Regent's Degree, Nominations, - - - - - 16, 30, 33, 427
Reinstating former Delinquent Members, Report of Committee on Ways and Means for, - - - - - - - - 27, 28
Resignations, - - - - - - - - - 15, 159

Resolutions: Delinquent Members, 27; Kali phos, Proving, 34; Middletown State Hospital, 168; Ophthalmia Neonatorum Circulars, 163; Tenets of Homœopathy, - - - - - - - - - - - - 11
"Responsibility of the Physician in the Treatment of Obscure Pelvic Disorders in Women," by B. F. Betts, - - - - - - - - 215
"Retrobulbar Neuritis, Three Cases of," by Chas. C. Boyle, - - - - 73
"Rhinitis, Hypertrophic, Treatment of," by C. E. Teets, - - - - 281
"Rhinitis Membranosa," by H. Worthington Paige, - - - - - 54
"Rhinitis, Ulcerative, following Diphtheria," by M. W. Van Denburg, - 280
Rhinology, Bureau of Laryngology and, - - - - - - 50, 272
ROPER, F. E., resigned, - - - - - - - - - - 159
SAGE, HENRY P., "Fracture of the Base of the Skull, with Delayed Symptoms," 343
SCHENCK, H. D., Necrologist's Report, 17; Remarks, - - - - - 67
SCHLEY, J. M., Reimbursed, 167; "Remarkable Toxic Effects of a Small Dose of Monobromacetanilide," 141; Prognosis in Organic Heart Disease, 189," "Some Suggestions on Adenoid Growths in the Naso-pharyngeal Space," 276; Remarks, - - - - - - - - - - 34, 280
Semi-annual Meeting, - - - - - - - - - - 150
"Senega in the Treatment of Hyperphoria and its Resultant Symptoms," by E. H. Linnell, - - - - - - - - - - - 321
SHAFER, LEVI, Dues Remitted, - - - - - - - - - 14
"Skull, Fracture of the Base of the, with Delayed Symptoms," by H. P. Sage and H. B. Minton, - - - - - - - - - - 343
SMITH, HENRY M., *in re* Hahnemann Statue, - - - - - - 165
SMITH, T. FRANKLIN, Remarks, - - - - - - - - 29
"Sound as a Factor in the Treatment of Disease of the Sound-conducting Apparatus," by H. C. Houghton, - - - - - - - - 334
STACY, FRED, I., Obituary of, - - - - - - - - 19
State Board of Medical Examiners, 6, 33, 429; Organization and Proceedings, 35, 411; Committee to Nominate for, - - - - - - 36
State Directory of Homœopathic Practitioners, - - - - - 447
"Static Electricity, Special Therapeutics of," by F. E. Caldwell, - - - 253
"Stomatitis," by J. Oscoe Chase, - - - - - - - - 203
STULL, OPHELIA S., Obituary of, - - - - - - - - 26
SULLIVAN, RICHARD B., Obituary of, - - - - - - - 26
"Sulphonal Homœopathically Considered," by F. Percy Jenks, - - - 86
Surgery, Bureau of, - - - - - - - - - - 114, 339
"Syphilis of the Mouth and Throat, with Treatment," by H. W. Paige, - - 285
TALCOTT, S. H., remarks, - - - - - - - - - 34
TEETS, CHAS. E., "Treatment of Hypertrophic Rhinitis," 281; Remarks, 54, 58, 59, 284
"Tendo-Achillis, Suturing the," by D. G. Wilcox, - - - - - - 339
Tenets of homœopathy, - - - - - - - - - - 10, 12
"The First Hours of Life," by Geo. W. Winterburn, - - - - - 101
"Throat, Syphilis of the Mouth and, with Treatment," by H. W. Paige, - 285
THORN, SARAH EDDY, dropped, - - - - - - - - - 14
Treasurer's Report, - - - - - - - - - - - 13
TRUE, R. S., dropped, - - - - - - - - - - 14
"Ulcer of the Cornea cured by Chin. Mur.," by A. G. Warner, - - - 331
"Uterus, A Radical Cure for Retro-displacements of the," by F. F. Lehman, - 114
"Ulcerative Rhinitis following Diphtheria," by M. W. Van Denburg, - - 280
TUTTLE, E. G., Remarks, - - - - - - - - - - 214

VAN DENBURG, M. W., Nominated for the Regent's Degree, 16, 33; "Has it been an Oversight?" 145; "Ulcerative Rhinitis following Diphtheria," 280; Remarks, - - - - - - - - - 15, 53, 59, 101
VAN LENNEP, W. B., Remarks, 213; "The Rectal Mucous Membrane as a Means of Preventing Infection in Operations about the Anus," - - - 225
WARD, JAMES H., Obituary of, - - - - - - - - - 25
WARNER, ALTON G., "Ulcer of the Cornea Cured by Chin. Mur.," 331; "Dislocation of the Lens and Subsequent Cataract by a shot from an Air Gun," - 332
WATSON, JAMES L., Resigned, - - - - - - - - - 159
WEST, JAMES A., dropped, - - - - - - - - - 14
WHITE, A. LENORA, "A Case, Discriminating Malposition of the Kidney from Pelvic Growths," 207; Remarks, - - - - - 213, 214
WILCOX, DEWITT G., "Suturing the Tendo-Achillis," 339; Remarks, - - 350
WILCOX, SIDNEY F., "Nephrorrhaphy, with a report of two operations for Movable Kidney," 128; "Three Cases of Appendicitis (?)—No Appendix, 345; Remarks, - - - - - - - - - - 127
WILLIS, HARRISON, Nominated for the Regent's Degree, 16, 33; "Cæsarian Section," 135; "Promiscuous Cases in Gynæcology and Surgery," - 360
WINTERBURN, GEORGE WILLIAM, "The First Hours of Life," 101; "The Fourth Stage of Labor," 240; "The Perinæum in its Relation to Normal Labor," 245; Remarks, - - - - - - - - 29, 184, 202, 256
WOLCOTT, EDWIN H., "Obstetrical Annoyances," 93; "The Forceps and Occipito-posterior Positions," - - - - - - - - - 235
ZIMMERMAN, CHAS., dropped, - - - - - - - - 14
Zinc Valerianate for chorea, - - - - - - - 182

3 ...
97+